

VR A15 (4)  
20M 1/65

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MEDICAL CERTIFICATION**

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04575 CERTIFICATE OF DEATH 04573											
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Water Station Run</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b> d. STREET ADDRESS <b>Water Station Run</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Graham</b> Last <b>Andrews</b>					4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 66</b>						
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>11/23/1885</b> 9. AGE (in years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR: Months <b>01</b> Days <b>1</b> IF UNDER 24 HRS. Hours <b>01</b> Min. <b>1</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William Waddell</b>					14. MOTHER'S MAIDEN NAME <b>Jane Graham</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Delma Cook</b> Address <b>Lonaconing, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> <b>4201</b> DUE TO (b) <b>Atherosclerotic CV Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced coronary artery disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>58</b> , to <b>April 6</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Mar. 30 1966</b> , and that death occurred at <b>A</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>L.R. Miles Jr</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4.7.66</b>				
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES JR MD</b>					22d. ADDRESS <b>Lonaconing Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lonaconing, Md.</b>					
24. FUNERAL DIRECTOR <b>George Eichhorn</b> <b>Lonaconing, Md</b>					25a. REC'D BY REGISTRAR <b>APR 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

Allegany

Maryland

Lonsconing

Lonsconing

Water Station Run

Water Station Run

Jane

Graham

Andrews

April

Female white

11/23/1885

Housewife

Lonsconing, Maryland

William Waddell

Jane Graham

Mrs. John Cook  
(deceased)

Lonsconing, Md.

Burial 11/2/85

Oak Hill Cemetery

Lonsconing

George Robinson

Lonsconing, Md

11/12/1885

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04576 CERTIFICATE OF DEATH 04574

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>65 years</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>301 Grand Avenue</b>				d. STREET ADDRESS <b>301 Grand Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Rose</b> Last <b>Apple</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1878</b>	
9. AGE (in years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>01</b> Min. <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Orleans Road, W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>William Light</b>			
14. MOTHER'S MAIDEN NAME <b>Rose Ann Householder</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>no</b>				17. INFORMANT <b>Miss Mary R. Apple, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42222</b> DUE TO (b) <b>myocarditis &amp; Decomposition</b> DUE TO (c) <b>Left Cerebral Hemorrhage</b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>6 min</b> <b>10 min</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>50</b> to <b>Apr 21</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Apr 21</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Clark E. Durrett</b>				M.D. <b>Dr. Clay E. Durrett, M.D.</b>		22b. DATE SIGNED <b>Apr. 22, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Clay E. Durrett, M.D.</b>				22d. ADDRESS <b>236 Virginia Ave., Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Apr. 23, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>				24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>			
25a. REC'D BY REGISTRAR <b>APR 26 1966</b>				25b. REGISTRAR'S SIGNATURE <b>f. Charles Judge</b>			

04571

04571

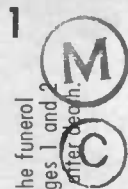
04571

APR 2 1962



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04577

CERTIFICATE OF DEATH

04575

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND-Allegany</b> b. COUNTY <b>XXXX XXXXXX</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>AVILTON FROSTBURG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>100 East Main St.</b>	
3. NAME OF DECEASED (Type or print) <b>BABY GIRL BAKER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>WHITE</b>	6. COLOR OR RACE <b>FEMALE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 7, 1966</b>
9. AGE (In years last birthday) yrs. <b>25</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>16</b> Hours <b>25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MOWRY BAKER</b>		14. MOTHER'S MAIDEN NAME <b>THELMA HUTZEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO <b>Pholapsis Cord</b> (b) <b>Breath Resuscitation - Prematurity</b> (c) <b>7615</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2:20 P.M.</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>2:20 P.M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>DR. AMERICO T. VALDES</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>ALGONQUIN HOTEL, CUMB. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 8, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Frostburg, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. RECD BY REGISTRAR <b>APR 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	

6-204641



04575

ALL EASY

CONCRETE AND

MEMORIAL HOSPITAL

BADLY

JOHN

WALKER

APRIL

WHITE FEMALE

NAME

HENRY BOKER

MEMORIAL HOSPITAL

THELMA HOTEL

BUNEL LAND, INC.

DR. AMERICO J. VACCES

ALYNDON HOTEL, CHICAGO, ILL.

APR 11 1936

04575

CERTIFICATE OF DEATH

HARRY AND A. MARKS CORP.

CHICAGO

22 APR.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04578

## CERTIFICATE OF DEATH

04576

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
c. LENGTH OF STAY IN 1b <b>18 DAYS</b>		d. STREET ADDRESS <b>103 DECATUR ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>REEXX PAULINE MARY BECK</b>		4. DATE OF DEATH Month Day Year <b>APRIL 5 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 5, 1904</b>
9. AGE (In years last birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN DEAN</b>		14. MOTHER'S MAIDEN NAME <b>ROSE BARTALON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-05-5930</b>	
17. INFORMANT <b>CART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4500</b> DUE TO <b>Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>Heart disease</b> (c) <b>Heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 30, 1966</b> to <b>April 5, 1966</b> that (I) (we) last saw the deceased alive on <b>April 5, 1966</b> , and that death occurred at <b>103 Decatur St.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>B. M. Schindler</b>		22b. DATE SIGNED <b>4/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. M. SCHINDLER, M.D.</b>		22d. ADDRESS <b>43 ERENE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 11, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARYS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>		25a. REC'D BY REGISTRAR <b>APR 11 1966</b>	
ADDRESS <b>CUMBERLAND, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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8520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR AIS (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04579					04577				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		ALLEGANY			e. STATE		b. COUNTY		
		MARYLAND			MARYLAND		ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
FROSTBURG			1 WEEK		FROSTBURG				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
MINERS HOSPITAL					76 BOWERY STREET				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
EOTTIE SARAH BEVAN					APRIL 22, 19 66				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		JANUARY 21, 1903		63 yrs.	
								IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
SEAMSTRESS			SHIRT FACTORY					U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
VINCENT S. RECKLEY					MARGARET DAILEY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT				
NO					Address: FROSTBURG, MD. MR. EDWARD V. BEVAN, 76 BOWERY STREET				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Heart Disease</i>									4 yrs.
4201 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Cancer of the Intestinal Tract</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (I) (this hospital) attended the deceased from <i>4/15</i> , 19 <i>66</i> to <i>4/22</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>4/22</i> , 19 <i>66</i> , and that death occurred at <i>3:55 P.</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Martin M. Rothstein M.D.</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>4/24/66</i>	
22c. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN, M.D.					22d. ADDRESS 48 BOWERY STREET, FROSTBURG, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)	
BURIAL			APRIL 25, 1966		FROSTBURG MEM. PARK FROSTBURG			MD.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>Hafer Funeral Home</i>					ADDRESS FROSTBURG, MD.			25e. REC'D BY REGISTRAR <i>Charles Judge</i>	
HAFER FUNERAL HOME, 60 W. MAIN ST.					APR 26 1966				

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CERTIFICATE OF DEATH

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04578

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PA.</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WELLERSBURG</b>	
c. LENGTH OF STAY IN 1b <b>7 HRS.</b>		d. STREET ADDRESS <b>75-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSELLA</b> Middle <b>MAY</b> Last <b>BRANT</b>		4. DATE OF DEATH Month <b>4-23-66</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1908</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Celanese employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WELLERSBURG, PA.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WELLERSBURG, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Sturtz</b>		14. MOTHER'S MAIDEN NAME <b>PATIENT'S CHART Goldie Stutz</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Lost</b>	
17. INFORMANT <b>Robert Brant, Wellersburg, Pa.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE, MASSIVE</b> DUE TO (b) <b>MALIGNANT HYPERTENSION</b> DUE TO (c) <b>HYPERTENSIVE HEART DISEASE</b> 441X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>15 YR.</b> <b>15 YR.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>LEFT HEMIPLEGIA</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>NONE</b> 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 22</b> , 19 <b>66</b> , to <b>APRIL 23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>APRIL 23</b> , 19 <b>66</b> , and that death occurred at <b>1:20AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James P. Hallinan</b>		22b. DATE SIGNED <b>4-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. JAMES P. HALLINAN M. D.</b>		22d. ADDRESS <b>140 BEDFORD ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 26 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Savage Methodist Mt. Savage, Maryland</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Harvey H. Leigler</b>		25a. REC'D BY REGISTRAR <b>APR 29 1966</b>	
ADDRESS <b>Lyndman, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04581 CERTIFICATE OF DEATH 04579

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>7 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				e. STREET ADDRESS <b>520 FECTIG ST.</b>			
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>L</b> Last <b>BROOKS</b>				4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-21-1893</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>							
13. FATHER'S NAME <b>Walter Hensel</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. (Shaw) Hensel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>SON FRANKLIN SCHILLING 520 FECTIG ST.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> , 19 <b>66</b> , to <b>4/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> , 19 <b>66</b> , and that death occurred at <b>3:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Leo H. Ley Jr.</b>				22b. DATE SIGNED <b>4/29/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Leo H. Ley Jr.</b>				22d. ADDRESS <b>456 N. Centre St. Cumberland Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR <b>Byron Knight</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>	
						25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04580

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>40 YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>424 N. MECHANIC STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>MAUNIE</b> Middle <b>E.</b> Last <b>BROOME</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>29</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>UNKNOWN</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>RAY W. BROOME</b> Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of right Hip</b> (c) <b>Arteriosclerotic cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>2 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) <b>Fell at home</b>			
20c. TIME OF INJURY Month, Day, Year <b>4:00</b> Hour <b>am</b> <b>April 29 66</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> <b>at work</b> <b>at work</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>				22. DATE SIGNED <b>April 30, 1966</b>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MAY 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>OAKLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				25. REC'D BY REGISTRAR <b>MAY 3 1966</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04581

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>XXXXXXXXXX</del> <b>Oldtown</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>none (Oldtown, Md.)</b>				d. STREET ADDRESS <b>none (Oldtown, Md.)</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Joseph</b> Last <b>Buskey</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 29, 1908</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.		IF UNDER 24 HRS. Months <b>57</b> Days <b>57</b> Hours <b>57</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George M. Buskey</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Decker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>705-05-4746</b>		17. INFORMANT <b>Mr. Richard C. Buskey, Cumberland, Md. - Son</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>4201</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				22. DATE SIGNED <b>April 12, 1966</b>			
Address (Street, city, town, or county) <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 15, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 15 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

13581

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13581

FOR FILING  
WITH THE  
DEATH CERTIFICATE

APR 15 1966

APR 15 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
04584						CERTIFICATE OF DEATH						04582	
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG,</b>				c. LENGTH OF STAY IN 1b <b>6 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG,</b>						01-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MINERS HOSPITAL</b>						d. STREET ADDRESS <b>37 W. FIRST STREET,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>LORETTA</b>		Middle <b>N.</b>		Last <b>CLARK</b>		4. DATE OF DEATH Month <b>APRIL</b>		Day <b>24th,</b>		Year <b>19 66</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 4th, 1893</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>MICHAEL NOLAN</b>						14. MOTHER'S MAIDEN NAME <b>ANNA O'REILLY</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>MRS. ANTHONY HOUCK, CUMBERLAND, MD.</b>		Address <b>13 N. Lee St.,</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma.</b> <b>1551</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Primary in Bile ducts.</b> DUE TO (c) <b>Regional &amp; Distant Metastasis</b>												INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Atherosclerosis</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>3-28</b> , 19 <b>66</b> , to <b>4-24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-24</b> 19 <b>66</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.													
22a. SIGNATURE <b>Alvin J. Walters</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>ALVIN J. WALTERS,</b>						22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-27-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEMETERY</b>				23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>					
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.,</b>						ADDRESS <b>FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information necessary, for state health department, is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04585 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04583

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>				c. LENGTH OF STAY IN lb <b>1 DAY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS' HOSPITAL</b>				d. STREET ADDRESS <b>LOARTOWN, R.F.D. #1, FROSTBURG</b>			
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First		Middle		Last	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 14, 1893</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>LOARTOWN, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN W. BLUBAUGH</b>				14. MOTHER'S MAIDEN NAME <b>MARY A. LOAR</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. WILLIAM E. CLISE, LOARTOWN, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> (b) <b>DISEASE</b> (c) <b>DISEASE</b> INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>---</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>APRIL 9, 1966</b> DATE SIGNED Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 12, 1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>VALE SUMMIT CEM.</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>VALE SUMMIT MARYLAND</b>	
23. FUNERAL DIRECTOR <i>Marlow M. Souers</i> <b>HAFER FUNERAL HOME, 60 W. MAIN STREET</b>				24a. REC'D BY REGISTRAR <b>APR 19 1966</b> 24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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04586

## CERTIFICATE OF DEATH

04584

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>HYNDMAN</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75-3</b> d. STREET ADDRESS <b>RT. 1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>A.</b> Last <b>CLITES</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-3-1905</b> 9. AGE (In years last birthday) yrs. <b>60</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>CHARLES MARTZ</b>		14. MOTHER'S MAIDEN NAME <b>EMMA HOSSELRODE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>181-38-7566</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial infarction</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>7d</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - Hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 1964</b> to <b>4-8, 1966</b> , that (I) (we) last saw the deceased alive on <b>4-8-66</b> 19 <b>66</b> , and that death occurred at <b>6:35 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>William P. James</b>		22b. DATE SIGNED <b>4/9/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM P. JAMES</b>		22d. ADDRESS <b>441 N. CENTRE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/11/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Porter Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hyndman, Pa. RD#1</b>
24. FUNERAL DIRECTOR <b>Lawrence H. Keebler</b>		25a. REC'D BY REGISTRAR <b>APR 13 1966</b>	
ADDRESS <b>Hyndman, Pa.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and regularly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04554

CERTIFICATE OF DEATH

04554

PENNSYLVANIA

ALLSANDY

HYNDMAN

7 DAYS

MEMORIAL HOSPITAL

RT. 1

MEMORIAL HOSPITAL

CL 4182

A.

ANNIE

11-3-1907

WHITE

PENNSYLVANIA

EMMA HUSS-BRODIE

CHARLES MORTZ

MEMORIAL HOSPITAL, KUMBERLAND, MD.

7 DAYS

WILLIAM P. JAMES

41 N. CORNHILL ST.

APR 13 1908

CERTIFICATE OF DEATH

04585

04587

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN lb <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>719 ARUNDEL ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ARTHUR P. CONNELL</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>19 66</b>					
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-2-1887</b>	9. AGE (In years last birthday) yrs. <b>78</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas CONNELL</b>			14. MOTHER'S MAIDEN NAME <b>MARY MURRAY</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-05-8177</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 DECOMPENSATED HEART DISEASE</b> DUE TO (b) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b> DUE TO (c) <b>?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>DIABETES AND PROSTATIC HYPERTROPHY</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>XXXXXX</del> attended the deceased from <b>11-9-64</b> , 19 <b>11</b> to <b>4-11-68</b> , that (I) <del>was</del> saw the deceased alive on <b>4-11-66</b> , 19 <b>11</b> , and that death occurred at <b>11:10 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Lusby</i>				22b. DATE SIGNED <b>4/11/66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. THOMAS F. LUSBY</b>	
22d. ADDRESS <b>932 NATIONAL HIGHWAY, La Vale, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-15-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04560

04560

STATE OF TEXAS

ALLIANCE

ALLIANCE

ALLIANCE

CONGESSLAND, MD.

3 DAYS

CONGESSLAND

719 ARUNDEL ST.

MEMORIAL HOSPITAL

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REAR

CONNELL

P.

ARTHUR

MALE

MALE

MARY MURRAY

CONNELL

MEMORIAL HOSPITAL, CONGESSLAND, MD.

DECOMPENSATED HEART DISEASE

ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE - 7 YEARS

DIABETES AND PROSTATIC HYPERTROPHY

11-0-00

11-0-00

11-0-00

932 NATIONAL HIGHWAY

MR. THOMAS E. LUGG

APR 18 1968

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18 for Civil Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04588

04588

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>6 years</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		d. STREET ADDRESS <b>Box 106 Bedford Road, Route 3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Ben Casteel Covey</b>		First Middle Last		4. DATE OF DEATH <b>April 17 1966</b>		Month Day Year		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 24, 1888</b>		9. AGE (In years last birthday) <b>78 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad trainman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad C&amp;N W RR</b>		11. BIRTHPLACE (State or foreign country) <b>Colby, Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Sam Covey</b>		14. MOTHER'S MAIDEN NAME <b>Janet ?</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>708 05 7145</b>		17. INFORMANT <b>Mrs. Lottie Covey, Box 106, Rt. 3, Cumberland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)															
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>April 17, 1966</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>															
24. FUNERAL DIRECTOR <b>John J. Hafer, 230 Baltimore Ave., Cumberland</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>															

04588

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 04-11-88 BY 1043 JRS/STP

1. NAME: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. RACE: [illegible]  
5. DATE OF BIRTH: [illegible]  
6. PLACE OF BIRTH: [illegible]  
7. OCCUPATION: [illegible]  
8. EDUCATION: [illegible]  
9. MARITAL STATUS: [illegible]  
10. RELIGION: [illegible]  
11. POLITICAL AFFILIATION: [illegible]  
12. SOCIAL SECURITY NUMBER: [illegible]  
13. CURRENT ADDRESS: [illegible]  
14. PREVIOUS ADDRESSES: [illegible]  
15. EMPLOYMENT HISTORY: [illegible]  
16. CRIMINAL RECORD: [illegible]  
17. PSYCHIATRIC HISTORY: [illegible]  
18. SUBSTANCE ABUSE HISTORY: [illegible]  
19. MENTAL HEALTH HISTORY: [illegible]  
20. PHYSICAL HEALTH HISTORY: [illegible]  
21. MEDICAL HISTORY: [illegible]  
22. SURGICAL HISTORY: [illegible]  
23. DRUGS: [illegible]  
24. ALCOHOL: [illegible]  
25. TOBACCO: [illegible]  
26. OTHER: [illegible]



FOR STATE HEALTH DEPT.

04589

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04587

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN 1b <b>23 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>225 Carroll Street</b>		d. STREET ADDRESS <b>225 Carroll Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Jessie</b> Middle <b>Deatelhauser</b> Last <b>Deatelhauser</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 30, 1886</b>
9. AGE (In years last birthday) <b>79 yrs.</b>		10. IF UNDER 1 YEAR Months <b>29</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Schilling</b>		14. MOTHER'S MAIDEN NAME <b>Louise Rice</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-6420</b>	
17. INFORMANT <b>Joseph T. Deatelhauser</b>		Address <b>16 Spruce Road Larchmont, N.Y.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY SCLEROSIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 29, 1966</b>	
Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>5/2/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rosehill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Maryland</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b> <b>Cumberland Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

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May 1 1966

CERTIFICATE OF DEATH

04590

04588

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CORRIGANVILLE</b>	
c. LENGTH OF STAY IN 1b <b>1 MO. 20 DAYS</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Gertrude Delbrook</b>		4. DATE OF DEATH Month Day Year <b>April 13 1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-88</b>
9. AGE (In years lost birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Wellersberg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>George W. Witt</b>		14. MOTHER'S MAIDEN NAME <b>Alice Witt</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Patient's Chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO (b) <b>Congestive Failure</b> DUE TO (c) <b>Severe Second + Third Degree Burns Body</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 20</b> , 19 <b>66</b> , to <b>April 13</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 12</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Richard Schindler</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <b>Dr. R. Schindler</b>		22d. ADDRESS <b>69 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 16, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wellersburg Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Wellersburg, Pa.</b>
24. FUNERAL DIRECTOR <b>Harvey H. Feigler</b>		ADDRESS <b>Hyndman, Pa.</b>	25a. REC'D BY REGISTRAR <b>APR 18 1966</b>
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

28540

04591

## CERTIFICATE OF DEATH

04589

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>7 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>647 N. MECHANIC ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>HALVIN</b> Middle <b>L.</b> Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-89</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>RICHARD EDWARDS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BUTLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5272</b> IMMEDIATE CAUSE (a) <u>Acute Virus Respiratory Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema &amp; Fibrosis; Anemia, severe</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/5</u> , 19 <u>66</u> , to <u>4/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>66</u> , and that death occurred at <u>1:54</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leo L. Ley</u>		22b. DATE SIGNED <u>4/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY</b>		22d. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 15, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany md.</b>	
24. FUNERAL DIRECTOR <b>Louis Stern, Inc. Cumberland, md.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

05280

01301

STATE OF TEXAS

APR 10 1966



04592

## CERTIFICATE OF DEATH

04590

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>28 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>101 RACE ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>AMANDA</b> Middle <b>MAY</b> Last <b>EIFERT</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-1886</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-CUMBERLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HARTSOCK ENSLEY, WARTSOCK</b>		14. MOTHER'S MAIDEN NAME <b>MARY WILSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Infarction</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Myocardial Infarction; Thrombosis, Left Ventricle</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>66</b> , to <b>4/5</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>4/4</b> , 19 <b>66</b> and that death occurred at <b>3:45 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Leo H. Hays Jr.</b>		22b. DATE SIGNED <b>4/8/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO LEY</b>		22d. ADDRESS <b>456 N. CENTRE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00520

CERTIFICATE OF DEATH

00520

ALLEGANY

MARYLAND

ALLEGANY

CUMBERLAND

28 DAYS

CUMBERLAND

101 RACE ST.

MEMORIAL HOSPITAL

ANANDA

EFFECT

10-1886

FEMALE WHITE

MARYLAND

ERLEY, MADDOCK

MARY WILSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

22 FEB 27

22 FEB 27

APR 1 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04593

CERTIFICATE OF DEATH

04594

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>210 CECELIA STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>J.</b> Last <b>EIRICH</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-1909</b>
9. AGE (In years last birthday) <b>56</b> yrs.		10. IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EIRICH, HENRY J.</b>		14. MOTHER'S MAIDEN NAME <b>SARAH HARRISON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>War II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) Pneumonia Lobar</b> <b>490x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>(2) Congenital Heart Failure</b> DUE TO <b>(3)</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thyroid - 2 years Thyroid Jan 1966 to March 66</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 5, 1966</b> to <b>April 8, 1966</b> ; that (I) (we) lost saw the deceased alive on <b>April 8, 1966</b> and that death occurred at <b>8:15 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>DR. G.O. HIMMELWRIGHT</b>		22b. DATE SIGNED <b>4/8/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 11, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

04591

04591

ALLEGANY  
COUNTY  
3 DAYS  
MAYLAND  
CUMBERLAND

MEMORIAL HOSPITAL

CHARLES

ELIZABETH

APRIL

10-3-1903

WHITE

MALE

MAYLAND

SARAH K. NELSON

ELIZABETH, NEWTON J.

MEMORIAL HOSPITAL, CUMBERLAND, MD.

DR. E. C. HINCHESBENT

133 VIRGINIA AVE., CUMBERLAND, MD.

APR 14 1906

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04594

CERTIFICATE OF DEATH

04592

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>103 WASHINGTON ST APT # A-1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROY W EVES</b>		4. DATE OF DEATH Month Day Year <b>APRIL 11 1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-86</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>1966</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>B&amp;O RR* EX* MAYOR</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>EVANSVILLE, IND.</b>	
13. FATHER'S NAME <b>WILLIAM (D)</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET D. (HOTSON) EVES (D)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>PT'S CHART</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive myocardial infarction</b> DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-10</b> , 19 <b>57</b> , to <b>4-11</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-11</b> , 19 <b>66</b> , and that death occurred at <b>8 p</b> M, from causes and on the date stated above.					
22a. SIGNATURE <i>Lois L. Ballin</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. BALLIN, M.D.</b>		22d. ADDRESS <b>62 GREENE ST. CUMBERLAND, MARYLAND.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/18/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR <b>Lois Stein Inc. Cumb. Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>APR 19 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and page 3 should be filed with the State Dept. of Health after death.

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04288

OFFICE OF THE

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## CERTIFICATE OF DEATH

04595

04593

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>12 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sylvan Retreat</b>		d. STREET ADDRESS <b>(Carlos)</b>	
3. NAME OF DECEASED (Type or print) First <b>Thursa</b> Middle <b>Fatkin</b> Last <b>Fatkin</b>		4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/9/77</b>
9. AGE (In years last birthday) yrs. <b>88 2/3</b>		10. IF UNOER 1 YEAR Months <b>30</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Adam</b>		14. MOTHER'S MAIGN NAME <b>Edith Griffith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. GEORGE FATKIN</b>		Address <b>FROSTBURG, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>① Virus pneumonia</b> <b>4222</b> DUE TO <b>② Myocarditis chr. degenerative</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>③ Atrial fibrillation, chr. degenerative, faint</b> DUE TO <b>④ Illness &amp; psychologic reaction</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF OATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 2, 1955</b> , to <b>April 30, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 29, 1966</b> , and that death occurred at <b>4:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. B. Mathews, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>L. B. Mathews, M.D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MAY 2, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG MD.</b>
24. FUNERAL DIRECTOR <b>HAFFER FUNERAL HOME, 60 W. MAIN ST.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00750

CHURCH OF DEATH

00750

(Gentle)

MAY 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04596 CERTIFICATE OF DEATH 04594											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG,</b>				c. LENGTH OF STAY IN 1b <b>50 YRS.</b>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>217 CENTER STREET</b>					d. STREET ADDRESS <b>217 CENTER STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JOHN</b>			First		Middle		Last <b>FILER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>8th</b> Year <b>1966</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 30th, 1884</b>		9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION CO.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>WILLIAM A. FILER</b>					14. MOTHER'S MAIDEN NAME <b>FRANCES PRICHARD</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>214-01-3595</b>		17. INFORMANT <b>MISS GRACE FILER,</b>		Address <b>217 CENTER ST., FROSTBURG, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> <b>1992</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Carcinoma of prostate &amp; probable</b> (c) <b>Carcinoma of pancreas</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>2/10/66</b> to <b>4/8/66</b> , that (I) (we) last saw the deceased alive on <b>4/6/66</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Walter H. Himmler</b>				M.D. <b>WALTER HIMMLER</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/9/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>WALTER HIMMLER</b>				22d. ADDRESS <b>412 N. MECHANIC ST., CYMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>			23d. LOCATION (City, town or county) (State) <b>FROSTBURG, MD.</b>				
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.,</b>						25a. REC'D BY REGISTRAR <b>APR 13 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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APR 13 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04597 CERTIFICATE OF DEATH 04595									
1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>			c. LENGTH OF STAY IN 1b <u>4 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDLOTHIAN</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MINERS HOSPITAL</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BEULAH</u> Middle <u>M.</u> Last <u>FINZEL</u>			4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>19 66</u>						
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14, 1906</u>		9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>59</u> Days <u>59</u>	IF UNDER 24 HRS. Hours <u>59</u> Min. <u>59</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>THOMAS HENDERSHOT</u>					14. MOTHER'S MAIDEN NAME <u>ANNA RALSTON</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>JAMES L. FINZEL, MIDLOTHIAN, MD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> <u>4201</u> DUE TO (b) <u>Arteriosclerotic CV disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4.7</u> , 19 <u>66</u> , to <u>4.10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4.10</u> 19 <u>66</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Leslie R. Miles</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4.11.66</u>		
22c. PHYSICIAN'S NAME (Type) <u>LESLIE R. MILES, M. D.</u>					22d. ADDRESS <u>LONACONING, MD.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>UNION GROVE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>CUMBERLAND, MD.</u>		
24. FUNERAL DIRECTOR <u>JOSEPH R. DURST, SR., FROSTBURG, MD.</u>					25a. REC'D BY REGISTRAR <u>APR 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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APR 13 1957



FOR STATE  
HEALTH DEPT

04598

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04596

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>58 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Oak Street</b>				d. STREET ADDRESS <b>Oak Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Fishell</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>24</b> Year <b>19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1907</b>			
9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John Grimm</b>				14. MOTHER'S MAIDEN NAME <b>Ida Grady</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Wm. J. Atkinson, Cumberland, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cor-Pulmonale---Pulmonary Emphysema, Marked</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>-----</b>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				Address (Street, city, town, or county) <b>Rt. 9 Cumberland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 27, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25. DATE <b>APR 26 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

6620

04599

## CERTIFICATE OF DEATH

04597

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>214 MASSACHUSETTS AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>EILEENE</b>		Lost <b>FISHER</b>		4. DATE OF DEATH Month <b>APRIL</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-29-20</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>12</b>		IF UNDER 24 HRS. Days <b>19</b>		Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee of Pgh Plate Glass Company</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GLASS COMPANY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Coleman</b>				14. MOTHER'S MAIDEN NAME <b>Grace Butler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-03-9420</b>		17. INFORMANT <b>PT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident (Pneumonia)</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 Pers</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-12</b> , 19 <b>66</b> , to <b>4-12</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>4-12</b> , 19 <b>66</b> , and that death occurred at <b>6:50 P.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>DR. M. G. SPITTLE</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-13-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. M. G. SPITTLE</b>				22d. ADDRESS <b>Smallwood St., CUMBERLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>	
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland Maryland 21502</b>		25a. REC'D BY REGISTRAR <b>APR 18 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

58220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04600  
BALTIMORE STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
04598

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corriganville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corriganville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oscar</u> <u>Burton</u> <u>Fleegle</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>6</u> <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1898</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	11. BIRTHPLACE (State or foreign country) <u>Corriganville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>David Fleegle</u>	
14. MOTHER'S MAIDEN NAME <u>Laura Shatzer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>220-10-3239</u>		17. INFORMANT Address <u>Md.</u> <u>Mrs. O. Burton Fleegle, Corriganville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated Carcinoma</u> <u>163X</u> DUE TO <u>Rt. Lung with metas.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(Note - Biopsy by Dr. Hadidian - Feb. 66)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <u>Not while</u> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/6/63</u> to <u>2/8/66</u> , that (I) (we) last saw the deceased alive on <u>2/8/66</u> , and that death occurred at <u>5A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Thomas F. Lushy</u> ATTENDING MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. DATE SIGNED <u>4/7/66</u>		22c. PHYSICIAN'S NAME (Type) <u>932 National Highway</u> <u>La Vale, Md. - 21504</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 9, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Mem. Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland, Md. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howey H. Zeigle</u>		25a. REC'D BY REGISTRAR <u>APR 11 1966</u>	
ADDRESS <u>Hyndman, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

STATE OF TEXAS  
OFFICE OF THE ATTORNEY GENERAL  
ATTEST: My commission expires \_\_\_\_\_  
\_\_\_\_\_  
NOTARY PUBLIC FOR THE STATE OF TEXAS

THOMAS F. LEE, JR.  
NOTARY PUBLIC  
EXPIRES JAN. 1, 1984

APR 11 1982



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04601					04599						
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE						
ALLEGANY MARYLAND					MARYLAND ALLEGANY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b							
FROSTBURG				5 DAYS							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS						
MINERS HOSPITAL					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
CHARLES			G.		FRANKENBERRY		APRIL		19 1966		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		NOV. 1, 1893		72 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
RETIRED TRUCKER				KELLY-SPFD. TIRE CO.		PENNSYLVANIA			U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
THOS. L. FRANKENBERRY					DARTHA MILLER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT						
YES			WW 1		RAY E. FRANKENBERRY, CRESAPTOWN, MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction due coronary thrombosis</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Severe Pulmonary Insufficiency due to Pulmonary Fibrosis</i>										INTERVAL BETWEEN ONSET AND DEATH <i>20 seconds</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>MAY</i> , 1962, to <i>4/19</i> , 1966, that (I) (we) last saw the deceased alive on <i>4/19</i> , 1966, and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Martin Rothstein</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>4/20/66</i>			
22c. PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN, M. D.						22d. ADDRESS 48 BROADWAY, FROSTBURG, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)			
BURIAL			4-22-1966		METHODIST CEMETERY			MT. SAVAGE, MD.			
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.						25a. REC'D BY REGISTRAR APR 22 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

04550

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04602 CERTIFICATE OF DEATH 04600

1. PLACE OF DEATH a. COUNTY <b>ALLEGHANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGHANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>123 N. CENTRE ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SCARED HEART HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALBERTHA</b> Middle <b>L</b> Last <b>FRANTZ</b>		4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>1966</b>					
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>5-27-77</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>22</b>		IF UNDER 24 HRS. Hours <b>19</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>ALLEGHANY</b>	
13. FATHER'S NAME <b>PERRY DEETZ</b>		14. MOTHER'S MAIDEN NAME <b>JANE CESSNA</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>PT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTEROSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>FRACTURE LEFT HIP</b>		INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4</b> , 19 <b>66</b> , to <b>4-22</b> , 19 <b>66</b> , that (I) (two) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>L. Michael Glick</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-25-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. MICHAEL GLICK</b>		22d. ADDRESS <b>126 N. SMALLWOOD ST. CUMBERLAND MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland MD</b>	
24. FUNERAL DIRECTOR <b>Louis Allen Inc - Cumb. Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

00000

CERTIFICATE OF DEATH

NOTED



APR 27 1966  
Bureau of Health Statistics  
State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04603

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

04601

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>334 Fayette Street</u>		d. STREET ADDRESS <u>334 Fayette St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Wilbur Roscoe Gaither</u>		4. DATE OF DEATH Month Day Year <u>April 27 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25 1902</u>
9. AGE (In years last birthday) <u>64 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineering Pk. W.M. R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elkins W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A</u>		13. FATHER'S NAME <u>Herbert Gaither</u>	
14. MOTHER'S MAIDEN NAME <u>Ella Taylor Cumb. Md.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. W. R. Gaither Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> <u>deced</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>—</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>104</u> <u>104</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Obesity</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>4/27/66</u> , that (I) (we) last saw the deceased alive on <u>March 19, 1966</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred W. W. D.</u> M.D.		22b. DATE SIGNED <u>4/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SG Weisman MD</u>		22d. ADDRESS <u>59 GREENE ST., CUMBERLAND, MD, 21502</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memo. Pk.</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steen Inc. Cumb. Md.</u>		25. REC'D BY REGISTRAR DATE <u>APR 29 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Juage</u>			

VR A15 (4)  
15M 9/60

40240



04604

## CERTIFICATE OF DEATH

04602

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>5 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>49 Linden Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>C</u> Last <u>Glorius</u>		4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/04</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Allegany Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Dailey</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Flahhagan</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u> DUE TO (b) <u>PULMONARY EMPHYSEMA</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>64</u> , to <u>4-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4-16</u> , 19 <u>66</u> , and that death occurred at <u>5:50 PM</u> , from causes and on the date stated above.	
22a. SIGNATURE <u>Dr. Glick &amp; Spiggle</u>		22b. DATE SIGNED <u>4-19-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Glick &amp; Spiggle</u>		22d. ADDRESS <u>126 N Smallwood Street</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-19-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAEL'S CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>FROSTBURG, MD.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH R. DURST, SR., FROSTBURG, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 21 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and it must be filed within 72 hours after death.

50320

2-2-17 330 10 974

04605

## CERTIFICATE OF DEATH

04603

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>89 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>E.</b> Last <b>GRAY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1877</b>
9. AGE (In years last birthday) <b>88-89 yrs.</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Antique Dealer-Own</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CUMBERLAND, MD.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE GRAY</b>		14. MOTHER'S MAIDEN NAME <b>ANNA GONSO</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Eugene Mason, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4330</b> IMMEDIATE CAUSE (a) <b>Adam-stokes Syndrome</b> DUE TO (b) <b>Cardiac Arrest</b> DUE TO (c) <b>arteriosclerotic Cardiac Vascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 to <b>1966</b> , 19, that (I) (we) last saw the deceased alive on <b>4/3/66</b> 19, and that death occurred at <b>8:27 PM</b> on the date stated above.			
22a. SIGNATURE <b>DR. GVERTON HIMMELWRIGHT</b>		22b. DATE SIGNED <b>4/4/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. GVERTON HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 6, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Camp Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Paw Paw, W. Va.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 12 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04608

CERTIFICATE OF DEATH

01005

ALLEGANY

MARYLAND

ALLEGANY COUNTY

CUMBERLAND

CUMBERLAND

852 LAFAYETTE AVE.

MEMORIAL HOSPITAL

CA

APRIL 1

GRAY

GEORGE

WHITE

MALE

CUMBERLAND, MD.

AME 60420

GEORGE GRAY

DR. OVERSTON JIMMELWRIGHT 133 VIRGINIA AVE. CUMBERLAND, MD.

APR 1 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

(M)

(I)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04606

CERTIFICATE OF DEATH

04604

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>7 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>123 S. SMALLWOOD ST.,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THEODORE</b> Middle <b>WALTER</b> Last <b>HAENFTLING</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>1</b> Year <b>19 66.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-1903</b>
9. AGE (In years lost birthday) yrs. <b>62</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Rwy.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>GILBERT E. HAENFTLING</b>		14. MOTHER'S MAIDEN NAME <b>EMMA APPEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Catherine Haenftling Smallwood</b>		18. ADDRESS <b>MEMORIAL HOSPITAL - CUMBERLAND, MD. ST.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tumor of brain, right, frontal lobe</b> DUE TO (b) <b>Arteriosclerosis of abd. aorta</b> DUE TO (c) <b>Arteriosclerosis of abd. aorta</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>1966</b> , that (I) (we) last saw the deceased alive on <b>4/1</b> 19 <b>66</b> , and that death occurred at <b>2:10 P.M.</b> from causes and on the date stated above.		22a. SIGNATURE <b>[Signature]</b>	
22b. DATE SIGNED <b>4/2/66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>	
22d. ADDRESS <b>59 GREENE ST., CUMBERLAND, MD.</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>APR 5 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

04000

CERTIFICATE OF DEATH

04000

ALLIANCE

WATKINS

ALLIANCE

CUMBERLAND

3 DAYS

CUMBERLAND

123 S. SMITHWOOD ST.

HOSPITAL HOSPITAL

APRIL

WATKINS

THEODORE

61

6-11-1903

WHITE

CUMBERLAND, PA.

OLBERT E. WATKINS

ELIZABETH

HOSPITAL HOSPITAL - CUMBERLAND, PA.



## CERTIFICATE OF DEATH

04605

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>21 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WEST VIRGINIA HAMPSHIRE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROMNEY, W.VA.</b> d. STREET ADDRESS <b>RT.#6</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GERTIE</b> First <b>G.</b> Middle <b>HAINES</b> Last		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 18, 1897</b>
9. AGE (In years and birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>5</b> Hours <b>19</b> Min. <b>66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA?</b>	
13. FATHER'S NAME <b>JOHN R. GLAZE</b>		14. MOTHER'S MAIDEN NAME <b>AMANDA MAE TEETER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>6000</b> IMMEDIATE CAUSE (a) <b>Chronic Pyelonephritis with</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemipia</b> DUE TO (c) <b>about 20 years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>4-5-66</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-15-66</b> , <b>4:25 P.M.</b> , that (I) (we) last saw the deceased alive on <b>19-66</b> , and that death occurred on the date stated above.			
21a. SIGNATURE <b>Howard L. Tolson</b>		21b. DATE SIGNED <b>4-6-66</b>	
22. PHYSICIAN'S NAME (Type) <b>DR. HOWARD L. TOLSON</b>		22d. ADDRESS <b>122 S. CENTRE ST. CUMB. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>April 8</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Forest Glenn</b>		23d. LOCATION (City or Town) (County) (State) <b>Greenspring Hamp. W.Va.</b>	
24. FUNERAL DIRECTOR <b>Dale L. Merritt</b>		25a. REC'D BY REGISTRAR <b>APR 7 1966</b>	
ADDRESS <b>404 Decatur Street Cumberland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

64205

01607

ALBANY

WEST VIRGINIA HAMPSHIRE

COMBING

21 DAYS

ROMNEY, W.VA.

MEMORIAL HOSPITAL

17.40

DEATH

HAIR

APRIL

FEMALE WHITE

JUNE 18, 1937

CUMBERLAND, CO.

JOHN R. GLAZE

AMANDA MARY GLAZE

MEMORIAL HOSPITAL

DR. HOWARD L. TOLSON 122 S. CENTRE ST. CUMS. MO.

APR. 1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04608  
CERTIFICATE OF DEATH  
04606

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4/29/1964</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>205 Davidson Street</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Ellen Heier</b>		4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/27/1886</b>
9. AGE (in years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Westernport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Henry Cavey</b>		14. MOTHER'S MAIDEN NAME <b>Rosie Belle Clupp</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X Hypertensive chn. degenerative</b> DUE TO (b) <b>2 Arterio sclerosis, Saccle</b> DUE TO (c) <b>3 Diabetes mellitus</b> <b>4 Drally leg amputation</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/29/64</b> , 19__, to <b>4/29/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>4/29/66</b> , 19__, and that death occurred at <b>A.</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Lee B. Mathews</b>		at <b>11:30 A. M.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
22b. DATE SIGNED <b>4/30/1966</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 2, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>Byron Kight</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04609  
CERTIFICATE OF DEATH  
04608

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>40 YEARS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>800 BEDFORD STREET</b>				e. STREET ADDRESS <b>800 BEDFORD STREET</b>					
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>J.</b> Last <b>HINZE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>19 66</b>					
5. SEX <b>FEMALE</b>		6. GOLD OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCT. 19, 1906</b>			
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY SCHOOLS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WABASH, INDIANA</b>			
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
13. FATHER'S NAME <b>FRANK SOWERBY</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA WHITE</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216 22 7136</b>		17. INFORMANT <b>H. FRANK HINZE</b>		Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Reticulum Cell Sarcoma with generalized metastases</b> 2000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2000</b>								INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>November</b> , 19 <b>60</b> , to <b>April 27</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 27</b> , 19 <b>66</b> , and that death occurred at <b>8:20M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Wyand F. Doerner</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. P. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <b>WYAND F. DOERNER, M.D.</b>		22b. DATE SIGNED <b>4-30-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>WYAND F. DOERNER, M.D.</b>				22d. ADDRESS <b>414 N. MECHANIC ST. CUMBERLAND, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 30, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HILLCREST CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON MIGHT</b>				ADDRESS <b>CUMBERLAND, MD.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04610 CERTIFICATE OF DEATH 04609									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN b <b>79 years</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>244 North Mechanic St.</b>					d. STREET ADDRESS <b>244 North Mechanic St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Caroline</b> Middle <b>Angela</b> Last <b>Holmes</b>			4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>19 66</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 8, 1886</b>		9. AGE (In years last birthday) <b>79 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Joseph T. Matt</b>					14. MOTHER'S MAIDEN NAME <b>Anna Lafferty</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Joseph P. &amp; Dorothy L. Holmes, Cumberland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>my flu</b> <b>481X</b> DUE TO <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>cerebral arteriosclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19 <b>4/29</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/25</b> 19 <b>66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Elizabeth G. Brings</b>					22b. DATE SIGNED			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Elizabeth G. Brings, M.D.</b>					22d. ADDRESS <b>55 Greene St., Cumberland, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>May 2, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>		
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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CHRONOLOGICAL LIST

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1954

1955

1956

1957

MAY 1958

1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04611

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Memorial Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> d. STREET ADDRESS <b>117 Grand Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EFFIE MAY HOLTZMAN</b> First Middle Last				4. DATE OF DEATH <b>April 14, 1966</b> Month Day Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 26, 1874</b> 91 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Flintstone, Maryland</b>	
13. FATHER'S NAME <b>Charles Swan Wilson</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Leonard E. Holtzman</b> Address <b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 4221 DUE TO (b) <b>Arteriosclerotic Cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture right Hip</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>XX</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Fell at home in Kitchen</b>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. <b>7:00 a.m.</b> p.m. <b>4/7 1966</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Alleg. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>April 14, 1966</b>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/17/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Wm. H. Hadd</b>		ADDRESS <b>121 Mem. Ave. Cumb. Md.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1944

MEMORANDUM FOR THE RECORD

1944

TO : THE CHIEF OF BUREAU

FROM : THE CHIEF OF BUREAU

SUBJECT : THE CHIEF OF BUREAU

RE : THE CHIEF OF BUREAU

DATE : THE CHIEF OF BUREAU

BY : THE CHIEF OF BUREAU

FOR : THE CHIEF OF BUREAU

BY : THE CHIEF OF BUREAU

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FOR : THE CHIEF OF BUREAU

BY : THE CHIEF OF BUREAU

04612

CERTIFICATE OF DEATH

04611

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN lb <b>26 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e. STREET ADDRESS <b>FROSTBURG, RT. 2,</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>J.</b> Last <b>HOPKINS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27,</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 23, 1908</b>
9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REFRACTORY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RICHARD HOPKINS</b>		14. MOTHER'S MAIDEN NAME <b>EVA DICKEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-10-9108</b>	
17. INFORMANT <b>MRS. ELEANOR HOPKINS, RT. 2, FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b> DUE TO <b>Bronchial Asthma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAR 26, 1966</b> to <b>APR 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>APR 27, 1966</b> , and that death occurred at <b>2:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>W. O. McLane</b>		22b. DATE SIGNED <b>APR 29 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLANE, M. D.</b>		22d. ADDRESS <b>E. MAIN ST., FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>4-30-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FB 'G. MEMORIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 2 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04613

# CERTIFICATE OF DEATH

Reg. Dist. No.

04612

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>		d. STREET ADDRESS <u>Douglas Avenue</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>James</u> Middle <u>J.</u> Last <u>Hotchkiss</u>		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>1</u> Year <u>19 66</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 7, 1907</u>
<b>9. AGE</b> (In years last birthday) yrs. <u>58</u>		<b>10. AGE</b> (In years last birthday) yrs. <u>58</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Railroad Employee</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Midland, Maryland</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Richard Hotchkiss</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Shearer</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>Mrs. Margaret Hotchkiss</u>		<b>Address</b> <u>Lonaconing, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma, with</u> <u>1621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Regional &amp; distant metastasis</u> DUE TO (c) <u>15 months.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia ; Terminal Pneumonia</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>March 16, 1966</u> , to <u>April 1, 1966</u> , that I last saw the deceased alive on <u>April 1, 1966</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <u>Alvin J. Walters</u>		<b>ADDRESS</b> (Street, city or town, state) <u>48 Broadway</u>	
<b>PHYSICIAN'S NAME</b> (Type) <u>Alvin J. Walters</u>		<b>DATE SIGNED</b> <u>Frostburg, Md.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4/4/66</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Laurel Hill Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Moscow, Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George Eichhorn</u>		<b>ADDRESS</b> <u>Lonaconing, Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>APR 5 1966</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

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04614

## CERTIFICATE OF DEATH

04613

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>7 HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b> d. STREET ADDRESS <b>821 BRADDOCK RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LLOYD HUMBERTSON</b>		4. DATE OF DEATH Month Day Year <b>APRIL 5 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-15-1900</b> 9. AGE (In years last birthday) yrs. <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Special Clerk-Celanese Corp</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENNA. SOMERSET CO.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>EDWIN HUMBERTSON</b>		14. MOTHER'S MAIDEN NAME <b>LILLY CUSTER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Route Failure</b> (c) <b>Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>78 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumbr. Alleg. Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4/4/66</b> , 19 to <b>4/5/66</b> , 19, that (I) (we) lost saw the deceased alive on <b>4/5/66</b> , 19, and that death occurred at <b>2:18 AM</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>		22b. DATE SIGNED <b>4/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland, Alleg. Md</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer</b>		25. REC'D BY REGISTRAR <b>APR 12 1966</b>	
25a. ADDRESS <b>230 Balto Ave., Cumberland, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04615 CERTIFICATE OF DEATH 04615									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>					d. STREET ADDRESS <b>1702 Bedford Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>First</b> <del>John</del> <b>David</b> <b>Middle</b> <b>NMI</b> <b>Last</b> <b>Jobson</b>					4. DATE OF DEATH <b>Month</b> <b>April</b> <b>Day</b> <b>17</b> <b>Year</b> <b>19 66</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 15, 1892</b>		9. AGE (in years last birthday) <b>73</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cost Accountant- Kelly S. Tire Co.</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Granville, New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Jobson</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Jones</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WW I 214-07-0512</b>		17. INFORMANT <b>pt. chart</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> <b>481X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Influenza</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardio-vascular disease</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 d yrs</b> <b>2 dys</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>5 - 17</b> , 19 <b>57</b> , to <b>4 - 17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4 - 17</b> , 19 <b>66</b> , and that death occurred at <b>4 p M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Ralph W. Ballin</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>4-18-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>					22d. ADDRESS <b>62 Greene S., Cumberland, Md. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/21/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Rt 3 Maryland</b>		
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b> <b>Cumberland</b> <b>Maryland</b>					25a. REC'D BY REGISTRAR <b>APR 20 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04616  
CERTIFICATE OF DEATH  
04616

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>67 years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Park Street</u>				d. STREET ADDRESS <u>101 Park Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Justina</u> Middle <u>Mae</u> Last <u>Kelly</u>				4. DATE OF DEATH Month <u>Apr.</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1899</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Harry Howard</u>				14. MOTHER'S MAIDEN NAME <u>Anna Sisco</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr. John C. Kelly, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE LEFT VENTRICULAR FAILURE</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERIOSCLEROSIS AND</u> DUE TO (c) <u>MYOCARDIAL FIBROSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>4 yrs?</u> <u>4 yrs?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral Insufficiency Cholelithiasis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) (County) (State) <u>  </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 16, 1962</u> to <u>APRIL 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>MARCH 15, 1966</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel M. Jacobson</u>				22b. DATE SIGNED <u>4-7-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Sr. Samuel M. Jacobson, MD</u>				22d. ADDRESS <u>50 Pershing St., Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Apr. 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>							
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

66816

RECORDS OF DEATH

APR 19 1966

Index of deaths in the year 1965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04617 CERTIFICATE OF DEATH 04617									
1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barton</b>				c. LENGTH OF STAY IN 1b <b>64 Yrs.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					6. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Earl</b> Last <b>Keyes</b>					4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 24, 1902</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plasterer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard E. Keyes,</b>					14. MOTHER'S MAIDEN NAME <b>Mary Muir</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-07-6768</b>		17. INFORMANT <b>Mrs. Elsie Keyes</b> Address <b>Barton, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>481X</b> <b>I lu (Respiratory infection)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Pulmonary emphysema</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Coronary Heart Failure</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>15 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1966</b> to <b>4/15/66</b> , that (I) (we) last saw the deceased alive on <b>4/11/66</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>William W. Lesh</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>William W. Lesh, MD</b>					22d. ADDRESS <b>Main St. Westernport, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Moscow Mills, Md.</b>			
24. FUNERAL DIRECTOR <b>E. J. Beal</b>					ADDRESS <b>Westernport, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

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04618

## CERTIFICATE OF DEATH

04618

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>19 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>436 N. CENTER ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Martha Keyser</b> First Middle Last 4. DATE OF DEATH <b>4 9 1966</b> Month Day Year		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>11-2-1897</b> 9. AGE (In years last birthday) yrs. <b>68</b> IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Eckhart, Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN STEWART</b> 14. MOTHER'S MAIDEN NAME <b>SARAH BONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Mr. Olin D. Keyser</b> Address <b>Cumb, Md. 436 N. Centre St.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>3-21, 1966</b> to <b>4-9, 1966</b> that (I) (we) last saw the deceased alive on <b>4-8, 1966</b> and that death occurred at <b>6:00 AM</b> , from causes and on the date stated above.	
22a. SIGNATURE <b>B. Schindler</b> 22c. PHYSICIAN'S NAME (Type) <b>B. SCHINDLER</b> 22d. ADDRESS <b>43 GREENE ST., CUMBERLAND, MD</b> 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. DATE SIGNED <b>4-9-66</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>4/12/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b> 23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b> 25a. REC'D BY REGISTRAR <b>APR 13 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04619

**CERTIFICATE OF DEATH**

04619

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN lb <b>29 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>409 Arch Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gladys A. Kime</b>				4. DATE OF DEATH Month Day Year <b>April 4 1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <b>11/04/03</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>West Virginia Purgittsville</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Wm. B. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Bessie R. Reel</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Pt. chart</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR HEMORRHAGE</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-6</b> , 19 <b>66</b> , to <b>4-2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-2</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE <i>L. Michael Glick</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. MICHAEL GLICK</b>				22d. ADDRESS <b>126 N. Smapewood Cumberland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-6-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 12 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01619

CERTIFICATE OF BIRTH

01619

NAME OF CHILD: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]

FATHER'S NAME: [illegible]  
MOTHER'S NAME: [illegible]  
FATHER'S OCCUPATION: [illegible]

DATE OF REGISTRATION: [illegible]  
PLACE OF REGISTRATION: [illegible]  
REGISTRAR'S SIGNATURE: [illegible]

LOCAL AUTHORITY: [illegible]  
LOCAL AUTHORITY SIGNATURE: [illegible]  
LOCAL AUTHORITY ADDRESS: [illegible]

LOCAL AUTHORITY ADDRESS: [illegible]  
LOCAL AUTHORITY ADDRESS: [illegible]  
LOCAL AUTHORITY ADDRESS: [illegible]

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LOCAL AUTHORITY ADDRESS: [illegible]  
LOCAL AUTHORITY ADDRESS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04620

CERTIFICATE OF DEATH

04620

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Roanoke</b> <del>Hamshire</del> <b>Hampshire</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Maryland</b>		c. LENGTH OF STAY in 1b <b>8 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Romney West Virginia</b>		85-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>276 E. Main St. Romney W.Va.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>A.</b> Last <b>Kirk</b>		4. DATE OF DEATH Month <b>4</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/83</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Hampshire County W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George S. Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Virginia (Parsons) Arnold</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Susan B. Arnold, Romney, West Virginia</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4200 Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Unk.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>APLASTIC ANEMIA IDIOPATHIC</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>3-25</b> , 19 <b>66</b> , to <b>4-2</b> , 19 <b>66</b> , that (H) (we) lost saw the deceased alive on <b>4-2</b> , 19 <b>66</b> , and that death occurred at <b>9A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>L. Michael Glick</b>		22b. DATE SIGNED <b>4/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. MICHAEL GLICK</b>		22d. ADDRESS <b>126 N. SMALLWOOD CUMBERLAND MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		23d. LOCATION (City or Town) (County) (State) <b>Roanoke Roanoke Va.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>APR 6 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

USA 29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04621 CERTIFICATE OF DEATH 04621									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>800 COLUMBIA AVENUE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>MAURICE</b> Middle <b>KIRK</b> Last <b>KIRK</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1966</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-25-1890</b>		9. AGE (In years, last birthday) <b>76</b> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Millwright</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Fibres</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES J. KIRK</b>					14. MOTHER'S MAIDEN NAME <b>AGNES HERSHBERGER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service) <b>W. W. # 1</b>				16. SOCIAL SECURITY NO. <b>214-07-4907</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> 4500 DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Advanced Pulmonary Emphysema &amp; fibrosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June, 1959</b> to <b>4-13, 1966</b> , that (I) (we) last saw the deceased alive on <b>4-13, 1966</b> , and that death occurred at <b>10:40 AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>William P. Saenger</b>					22b. DATE SIGNED <b>4/14/66</b>			22c. PHYSICIAN'S NAME (Type) <b>DR. WILLIAM JAMES</b>	
22d. ADDRESS <b>441 N. CENTRE ST. CUMBERLAND, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/16/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Md</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

00001

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CUMBERLAND

5 DAYS

CUMBERLAND

800 COLUMBIA AVENUE

MEMORIAL HOSPITAL

APRIL

KIRK

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3-25 1890

MALE WHITE

MALE

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ALL ARE

JAMES J. KIRK

JOHN HENDERSON

MEMORIAL HOSPITAL, CUMBERLAND, MD.

21-07-17

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411 E. CENTRE ST. CUMBERLAND, MD.

D. WILLIAM JAMES

*[Faint, illegible handwritten text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04622 CERTIFICATE OF DEATH 04622									
1. PLACE OF DEATH a. COUNTY <u>Alleghany</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alleghany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u> 01-1 d. STREET ADDRESS <u>439 Walnut Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>M.</u> Last <u>Klosterman</u>					4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-4-99</u>		9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jerry Free</u>					14. MOTHER'S MAIDEN NAME <u>Bessie Worsing</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Co of Right Pneumonia/secondary</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1965</u> , to <u>April 24, 1966</u> that (I) (we) last saw the deceased alive on <u>4/24/66</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Blane Schindler</u>				22b. DATE SIGNED <u>4/25/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Blane Schindler M.D.</u>				22d. ADDRESS		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Rt 3 Maryland</u>			
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>				ADDRESS <u>Cumberland Maryland 21502</u>		25a. REC'D BY REGISTRAR <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04888

CERTIFICATE OF DEATH

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John

Alfred

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Constance

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1918

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04623

CERTIFICATE OF DEATH

04623

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>147 POLK ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ENDICH F. LEASURE</b>				4. DATE OF DEATH Month Day Year <b>APRIL 14 19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-1896</b>	
9. AGE (In years lost birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bootmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>JAMES S. LEASURE</b>			
14. MOTHER'S MAIDEN NAME <b>ROSE MC KENZIE LEASURE</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>770</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>PATIENT'S CHART</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease, Failure</b> <b>Cerebral Vasc. Accident</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/13</b> , 19 <b>66</b> , to <b>4/14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/14</b> , 19 <b>66</b> , and that death occurred at <b>5:30</b> A.M., from causes and on the date stated above.							
22a. SIGNATURE <b>Leo Ley</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO LEY,</b>				22d. ADDRESS <b>456 N. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Pk.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>				25a. REC'D BY REGISTRAR <b>APR 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25320

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

04624

04624

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> <span style="float: right;">c. LENGTH OF STAY IN 1b</span> <u>3/25/64</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Allegany County Infirmary</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) (Sue) <u>Susie Almira McFarland</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>23</u> Year <u>1966</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8/27/1883</u>		<b>9. AGE</b> (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>George McFarland</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret Chrismore</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>P.O. Box 599, Address Cumberland, Md</u> <u>Allegany County Infirmary records.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis chr. degenerative</u> <u>350X</u> DUE TO (b) <u>Arterio sclerosis &amp; Hypotension</u> (c) <u>Parkinsons disease</u> DUE TO (d) <u>Chronic open abdominal aorta</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/25/64</u> , 19____, to <u>4/23/66</u> , 19____, that (I) (we) last saw the deceased alive on <u>4/22/66</u> , 19____, and that death occurred at <u>A</u> M., from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <u>Lee B. Mathews</u>				<b>22b. DATE SIGNED</b> <u>4/23/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Lee B. Mathews, M. D.</u>		<b>22d. ADDRESS</b> <u>49 Greene St., Cumberland, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Apr. 26, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Oldtown M.E. Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Oldtown, Md.</u>			
<b>24. FUNERAL DIRECTOR</b> <u>James F. Scarpelli, Cumberland, Md.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>APR 26 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04625

04625

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY in 1b <b>LIFETIME</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>20 TAYLOR STREET</b>		d. STREET ADDRESS <b>20 TAYLOR STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>EMMETT</b> Middle <b>MC GUIRE</b> Last <b>MC GUIRE</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 24, 1904</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF-EMPLOYED</b>	9. AGE (In years last birthday) yrs. <b>61</b>
11. BIRTHPLACE (State or foreign country) <b>FROSTBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PETER MC GUIRE</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET EAGAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-05-6865</b>	
17. INFORMANT <b>MRS. EMMETT MCATEER, 20 TAYLOR STREET</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO (b) <b>CORONARY SCLEROSIS</b> DUE TO (c) <b>---</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		22. DATE SIGNED <b>April 28, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cumberland, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APR. 30, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAEL'S CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>M. Sowers</b>		25a. REC'D BY REGISTRAR <b>MAY 2 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

HAFFER FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD.

25340

MAY 3 1966

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04626

CERTIFICATE OF DEATH

04626

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 DAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. STREET ADDRESS <b>122 WALNUT ST</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARIE EVELYN MC KENZIE</b>		4. DATE OF DEATH Month Day Year <b>APRIL 12 1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-19</b>
9. AGE (In years last birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CLAIM EXAMINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STATE EMPLOYMENT</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>SHAFT, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ERNEST B. McKENZIE</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE STEVENSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>R15-10-4447</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>- Coma.</b> DUE TO (b) <b>Probably hypoxia -</b> DUE TO (c) <b>massive carcinoma larynx &amp; metastasis.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Vicente M. Valls</b>		22b. DATE SIGNED <b>4-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>VICENTE M. VALLS, MD.</b>		22d. ADDRESS <b>113 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>APR. 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FB'G. MEMORIAL PARK</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REG'D BY REGISTRAR <b>APR 18 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

85320

STATE OF TEXAS

85320

Section		Twp		Range		County		State	
36		10N		10E		Harris		Texas	
Block		Lot		Acres		Owner		Remarks	
1		1		1.00		John Doe		Acquired by deed	
2		2		1.00		Jane Smith		Acquired by deed	
3		3		1.00		Robert Johnson		Acquired by deed	
4		4		1.00		Mary White		Acquired by deed	
5		5		1.00		James Brown		Acquired by deed	
6		6		1.00		Elizabeth Green		Acquired by deed	
7		7		1.00		William Black		Acquired by deed	
8		8		1.00		Susan Gray		Acquired by deed	
9		9		1.00		Thomas Red		Acquired by deed	
10		10		1.00		Patricia Blue		Acquired by deed	
11		11		1.00		Michael Yellow		Acquired by deed	
12		12		1.00		Jennifer Purple		Acquired by deed	
13		13		1.00		Christopher Pink		Acquired by deed	
14		14		1.00		Amanda White		Acquired by deed	
15		15		1.00		Daniel Brown		Acquired by deed	
16		16		1.00		Michelle Green		Acquired by deed	
17		17		1.00		Kevin Black		Acquired by deed	
18		18		1.00		Nicole Gray		Acquired by deed	
19		19		1.00		Brandon Red		Acquired by deed	
20		20		1.00		Stephanie Blue		Acquired by deed	
21		21		1.00		Tyler Yellow		Acquired by deed	
22		22		1.00		Ashley Purple		Acquired by deed	
23		23		1.00		Jonathan Pink		Acquired by deed	
24		24		1.00		Katherine White		Acquired by deed	
25		25		1.00		Nathan Brown		Acquired by deed	
26		26		1.00		Heather Green		Acquired by deed	
27		27		1.00		Aaron Black		Acquired by deed	
28		28		1.00		Rebecca Gray		Acquired by deed	
29		29		1.00		Adam Red		Acquired by deed	
30		30		1.00		Christina Blue		Acquired by deed	
31		31		1.00		Dustin Yellow		Acquired by deed	
32		32		1.00		Crystal Purple		Acquired by deed	
33		33		1.00		Austin Pink		Acquired by deed	
34		34		1.00		Danielle White		Acquired by deed	
35		35		1.00		Jesse Brown		Acquired by deed	
36		36		1.00		Brittany Green		Acquired by deed	
37		37		1.00		Jordan Black		Acquired by deed	
38		38		1.00		Alexis Gray		Acquired by deed	
39		39		1.00		Miguel Red		Acquired by deed	
40		40		1.00		Samantha Blue		Acquired by deed	
41		41		1.00		Liam Yellow		Acquired by deed	
42		42		1.00		Olivia Purple		Acquired by deed	
43		43		1.00		Noah Pink		Acquired by deed	
44		44		1.00		Sophia White		Acquired by deed	
45		45		1.00		Ethan Brown		Acquired by deed	
46		46		1.00		Isabella Green		Acquired by deed	
47		47		1.00		Caleb Black		Acquired by deed	
48		48		1.00		Mia Gray		Acquired by deed	
49		49		1.00		Isaac Red		Acquired by deed	
50		50		1.00		Layla Blue		Acquired by deed	
51		51		1.00		Nolan Yellow		Acquired by deed	
52		52		1.00		Aria Purple		Acquired by deed	
53		53		1.00		Carter Pink		Acquired by deed	
54		54		1.00		Evelyn White		Acquired by deed	
55		55		1.00		Gabriel Brown		Acquired by deed	
56		56		1.00		Hannah Green		Acquired by deed	
57		57		1.00		Isiah Black		Acquired by deed	
58		58		1.00		Jocelyn Gray		Acquired by deed	
59		59		1.00		Josiah Red		Acquired by deed	
60		60		1.00		Kaitlyn Blue		Acquired by deed	
61		61		1.00		Kian Yellow		Acquired by deed	
62		62		1.00		Kristina Purple		Acquired by deed	
63		63		1.00		Landon Pink		Acquired by deed	
64		64		1.00		Leah White		Acquired by deed	
65		65		1.00		Logan Brown		Acquired by deed	
66		66		1.00		Madeline Green		Acquired by deed	
67		67		1.00		Malik Black		Acquired by deed	
68		68		1.00		Marissa Gray		Acquired by deed	
69		69		1.00		Mateo Red		Acquired by deed	
70		70		1.00		Maya Blue		Acquired by deed	
71		71		1.00		Miguel Yellow		Acquired by deed	
72		72		1.00		Morgan Purple		Acquired by deed	
73		73		1.00		Natalie Pink		Acquired by deed	
74		74		1.00		Nathan White		Acquired by deed	
75		75		1.00		Oliver Brown		Acquired by deed	
76		76		1.00		Pamela Green		Acquired by deed	
77		77		1.00		Parker Black		Acquired by deed	
78		78		1.00		Quinn Gray		Acquired by deed	
79		79		1.00		Rafael Red		Acquired by deed	
80		80		1.00		Reagan Blue		Acquired by deed	
81		81		1.00		Riley Yellow		Acquired by deed	
82		82		1.00		Savannah Purple		Acquired by deed	
83		83		1.00		Sebastian Pink		Acquired by deed	
84		84		1.00		Shelby White		Acquired by deed	
85		85		1.00		Silas Brown		Acquired by deed	
86		86		1.00		Skylar Green		Acquired by deed	
87		87		1.00		Stacy Black		Acquired by deed	
88		88		1.00		Tanner Gray		Acquired by deed	
89		89		1.00		Tiana Red		Acquired by deed	
90		90		1.00		Tyler Blue		Acquired by deed	
91		91		1.00		Uma Yellow		Acquired by deed	
92		92		1.00		Victor Purple		Acquired by deed	
93		93		1.00		Wendy Pink		Acquired by deed	
94		94		1.00		Xavier White		Acquired by deed	
95		95		1.00		Yara Brown		Acquired by deed	
96		96		1.00		Zoe Green		Acquired by deed	
97		97		1.00		Adam Black		Acquired by deed	
98		98		1.00		Alexa Gray		Acquired by deed	
99		99		1.00		Anthony Red		Acquired by deed	
100		100		1.00		Ashley Blue		Acquired by deed	

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following are necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04627 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing, Md.</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Keyser,</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Home of Friend</b>				d. STREET ADDRESS <b>Corwin Hotel 115 N. Main St.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>James</b> Last <b>Melvin</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5, 1905</b>	
9. AGE (in years last birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		11. BIRTHPLACE (State or foreign country) <b>Midland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John William Melvin</b>				14. MOTHER'S MAIDEN NAME <b>Effie Morris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes Navy</b>				16. SOCIAL SECURITY NO. <b>214-07-6377</b>			
17. INFORMANT <b>Elizabeth Stemple, Keyser, W. Va.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Coronary Sclerosis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarellic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, MD.</b>				DATE SIGNED <b>XX April 17, 1966</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4-19-66</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Westernport, Md.</b>			
23. FUNERAL DIRECTOR <b>Thermon Smith</b>				24. REC'D BY REGISTRAR <b>APR 21 1966</b>			
Address <b>Keyser, W. Va.</b>				25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 (M)

04628

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04628

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Cumberland</b>		c. LENGTH OF STAY IN lb <b>22 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>		d. STREET ADDRESS <b>809 Maryland Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Harvey</b> Middle <b>Jacob</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10, 1924</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cafe</b>	9. AGE (In years last birthday) yrs. <b>42</b>
11. BIRTHPLACE (State or foreign country) <b>Fairhope, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles D. Miller</b>		14. MOTHER'S MAIOMEN NAME <b>Elsie R. Deneen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Ella Hall, Cumberland, Md.</b>		Address <b>Sister</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS AND HYPERTENSIVE CARDIOVASCULAR DISEASE</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		22. DATE SIGNED <b>APRIL 12, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Apr. 15, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Miller Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Fairhope, Penna.</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25. REC'D BY REGISTRAR <b>APR 15 1966</b>	
25a. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1000

APR 1 1966

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04629

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04629

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>01-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>403 Pennsylvania Avenue</u>		d. STREET ADDRESS <u>403 Pennsylvania Av</u>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>A.</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1898</u>
9. AGE (In years last birthday) yrs. <u>67</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Norris</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Belle Ruby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Walter W. Logue, Cumberland, Md.</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>-----</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic, N. D.</u>		Address (Street, city, town, or county) <u>Rt. 9, Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>May 2, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Herman Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md. Allegany</u>
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>  </u>	

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04630

## CERTIFICATE OF DEATH

04630

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leo</b> Middle <b>Vernon</b> Last <b>Mills</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-7-13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	9. AGE (In years last birthday) yrs. <b>52</b>
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND Cumberland,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Leroy V. Mills</b>		14. MOTHER'S MAIDEN NAME <b>CARRIE MAE Imes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes, W. V. # 2</b>		16. SOCIAL SECURITY NO. <b>217-10-4688</b>	
17. INFORMANT <b>Mrs. Charlotte Mills Rt. # 1 Ridgeley, W. Va.</b>		PATIENTS CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding esophageal varices</b> DUE TO (b) <b>Hepatic cirrhosis</b> DUE TO (c) <b>Chronic ethanolism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-1</b> , 19 <b>66</b> , to <b>4-6</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>4-6</b> 19 <b>66</b> , and that death occurred at <b>2:03 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. C. Spiggle</b>		22b. DATE SIGNED <b>4-7-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. C. Spiggle, M.D.</b>		22d. ADDRESS <b>126 N. Smallwood St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/9/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Maryland</b>
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 12 1966</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





04631

CERTIFICATE OF DEATH

04631

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN lb <b>11 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BARTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>MOWBRAY</b> Last <b>MOWBRAY</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-18-1889</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BARTON, MD.</b>	
13. FATHER'S NAME <b>JOHN MOWBRAY</b>				14. MOTHER'S MAIDEN NAME <b>MARY DARLING</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-2980</b>		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5231</b> DUE TO <b>Chronic Pulmonary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Pulmonary fibrosis + emphysema</b> (c) <b>Chronic - Silicosis</b>							
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/11</b> , 19 <b>66</b> to <b>4/22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/21</b> , 19 <b>66</b> , and that death occurred at <b>5:12 A.M.</b> from causes on and on the date stated above.							
22a. SIGNATURE <b>S. G. Weisman</b>				22b. DATE SIGNED <b>4/23/66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>	
22d. ADDRESS <b>59 GREENE ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Moscow Mills, Md</b>	
24. FUNERAL DIRECTOR <b>E. J. Brown</b>				ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 27 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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ALLIE GARY

MARYLAND

ALLEGANY

BARTON

11 DAYS

OF MARYLAND

MEMORIAL HOSPITAL

APRIL 22

MURRAY

THOMAS

18 1898

MALE WHITE

BARTON, MD.

MARY GARY

JOHN M. GARY

MEMORIAL HOSPITAL - CHURCHLAND, MD.

APR 21 1952

DR. S. E. WEISSMAN

DR. G. E. GREENE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
04632					04632				
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McCOOLE</b>			c. LENGTH OF STAY IN 1b <b>13 MONTHS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			d. STREET ADDRESS <b>221 CARROLL STREET</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>THORNE NURSING HOME</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>B.</b> Last <b>MULLAN</b>					4. DATE OF DEATH Month <b>APRIL</b> Day <b>17</b> Year <b>19 66</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 21, 1887</b>		9. AGE (In years last birthday) <b>78</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B. &amp; O. RR</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>WILLIAM T. MULLAN</b>					14. MOTHER'S MAIDEN NAME <b>ANNA CARLOS</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705-05-4827</b>		17. INFORMANT <b>PAUL A. MULLAN</b>			Address <b>CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke</b> <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , 19____, to <b>12/21/66</b> , 19____, that (I) (we) last saw the deceased alive on <b>19____</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Clinton L Rogers</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Clinton L Rogers</b>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. PETER &amp; PAUL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CUMBERLAND, MD.</b>			
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b> <b>CUMBERLAND, MD.</b>					25a. REC'D BY REGISTRAR <b>APR 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

01638

DEATH RECORDS  
CUMBERLAND, MD.

ALLEGANY

NEWCASTLE

ALLEGANY

CUMBERLAND

WADSWORTH

221 CARROLL STREET

THOMAS WADSWORTH HOME

APRIL 1917

MULLAN

B.

ALBANY

19

JULY 27, 1917

WHITE

MALE

MARYLAND

ALLEGANY

B. & O. RR.

MACHINIST

ADNA CARLOS

WILLIAM T. BULLAN

CUMBERLAND, MD.

PAUL A. MULLAN

NO

APRIL 20, 1917 ST. PETER & PAUL CEMETERY CUMBERLAND, MD.

BYRON KIRK CUMBERLAND, MD.

ADNA CARLOS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
04633			CERTIFICATE OF DEATH		
04633			04633		
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VIRGINIA</b> b. COUNTY <b>MINERAL</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>4 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELEY</b> 85-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			d. STREET ADDRESS <b>178 MAIN STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>JASON</b> Middle <b>Clinton</b> Last <b>NELSON</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>19 66</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 7, 1892</b>	9. AGE (In years last birthday) yrs. <b>73</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Calendar Rm. Emp. Kelly-Tire Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Tire Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>DAVID NELSON</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes, W. W. # 1</b>			16. SOCIAL SECURITY NO. <b>W. W. # 1</b>		
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.V.R.</b> 4221 DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <b>Cumberland, Md.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>2/4/63</b> , 19____, to <b>4/15/66</b> , 19____, that (I) (we) last saw the deceased alive on <b>4/15/66</b> , 19____, and that death occurred at <b>6:30 A.M.</b> on <b>4/15/66</b> , 19____, from causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Maryland</b>		
24. FUNERAL DIRECTOR <b>H. Wayne George Cumberland, Maryland</b>			25a. REC'D BY REGISTRAR <b>APR 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

04638

04638

CONFIDENTIAL

ALLIANCE

W. VIRGINIA

RIDGELY

3 DAYS

MEMORIAL HOSPITAL

138 MAIN STREET

REASON

LAST

DEC. 7, 1932

MALE WHITE

WEST VIRGINIA

JOHN E. KETTERMAN

DAVID KELSON

MEMORIAL HOSPITAL - CHRISTIAN, W.V.

OF R. O. WILLIAMS

123 S. CENTRAL ST., CHRISTIAN, W.V.

APR 10 1938

*Handwritten signature*



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04634  
CERTIFICATE OF DEATH  
04634

1. PLACE OF DEATH a. CDUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSHUA</b> Middle <b>T.</b> Last <b>PERRIN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-17-99</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Everett, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE Perrin</b>		14. MOTHER'S MAIDEN NAME <b>SUSIE WIGFIELD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left ventricular failure</b> <b>4221</b> DUE TO <b>Arteriosclerotic CVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic CVD</b> OUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-12</b> , 19 <b>66</b> , to <b>4-15</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-15</b> , 19 <b>66</b> , and that death occurred at <b>7p</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED <b>4-16-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RALPH W. BALLIN, MD.</b>		22d. ADDRESS <b>62 GREENE ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>4/18/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Allegany Co.</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland MD</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc, Cumb. MD.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT

04635

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04635

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>99</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hosp (D.O.A.)</b>		e. STREET ADDRESS <b>129 Greene Street</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <b>Ernest M. Powell</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1905</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>01</b> Days <b>11</b> Hours <b>11</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Cumberland</b>
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Walter J. Powell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Allender</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Ernest M. Powell, Cumberland Md</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 21, 1966</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>		23. LOCATION (City or Town) (County) (State) <b>Cumberland Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/25/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem</b>		23d. REC'D BY REGISTRAR <b>Louis Stein Inc. Cumberland Md</b>		23e. REGISTRAR'S SIGNATURE <b>APR 25 1966</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
04636											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>6 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>34 WASHINGTON ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EVA MARIE PRICE</b> First Middle Last					4. DATE OF DEATH <b>APRIL 16th, 1966</b> Month Day Year						
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-9-96</b>		9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ERNEST SCHELL</b>					14. MOTHER'S MAIDEN NAME <b>OLLIE CROSS</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>PATIENT'S CHART</b> Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA BILATERAL</b> <b>480X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>INFLUENZA SYNDROME</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ADRENAL INSUFFICIENCY</b>										INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>4-10</b> , 19 <b>66</b> , to <b>4-16</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4-16</b> , 19 <b>66</b> , and that death occurred at <b>4:30</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>L. Michael Glick</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-16-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>L. MICHAEL GLICK</b>					22d. ADDRESS <b>126 N. SMALLWOOD CUMBERLAND</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4-19-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>			23d. LOCATION (City, town or county) (State) <b>Frostburg, Md.</b>				
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.,</b> ADDRESS <b>FROSTBURG, MD.</b>					25a. REC'D BY REGISTRAR <b>APR 21 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04637

# CERTIFICATE OF DEATH

04637

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>15 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			d. STREET ADDRESS <b>130 SEYMOUR ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTHA PROUDFOOT</b>			4. DATE OF DEATH Month Day Year <b>APRIL 24 19 66</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 11, 1889</b>		9. AGE (In years last birthday) yrs. <b>76</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>	
13. FATHER'S NAME <b>HARRY COLEMAN</b>			14. MOTHER'S MAIDEN NAME <b>LUCETTA, DUGAN</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334x Arterio Sclerotic Cerebro Vascular Disease</b> DUE TO (b) <b>Stroke</b> DUE TO (c) <b>Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>4-72</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Secondary Pneumonia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumberland, Md.</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7/7/62</b> to <b>4/24/66</b> , 19 <b>66</b> that (I) (we) lost saw the deceased alive on <b>4/24/66</b> 19 <b>66</b> , and that death occurred at <b>4:10 P.M.</b> on the date stated above.					
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>
22d. ADDRESS <b>122 S. CENTRE ST. CUMBERLAND, MD.</b>			22e. M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		23e. REC'D BY REGISTRAR <b>APR 29 1966</b>			
24. FUNERAL DIRECTOR <b>Charles H. Steward</b> Cumberland, Maryland		25b. REGISTRAR'S SIGNATURE <b>Charles H. Steward</b>			

04037

CERTIFICATE OF DEATH

04037

MARYLAND

ALLIANCE

CUMBERLAND

CUMBERLAND

10 DAYS

100 SEYMOUR ST.

MEMORIAL HOSPITAL

PROVIDENCE

DEPT.

OCT. 11, 1955

REPA E WHITE

WEST VIRGINIA

LUETTA, DUGAN

HARRY ROEMER

MEMORIAL HOSPITAL

APR 20 1956

DEPT. OF HEALTH

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04638

## CERTIFICATE OF DEATH

04638

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>13 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>Rural Mt. Savage</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William E. Rice</b>		4. DATE OF DEATH Month Day Year <b>4 25 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/2/96</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR Months Days <b>25 19 66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mining</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Perry Rice</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Resser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W. I</b>		16. SOCIAL SECURITY NO. <b>215-10-1231</b>	
17. INFORMANT <b>Chart</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 5271 DUE TO and <b>Pulmonary fibrosis</b> DUE TO <b>Pulmonary emphysema</b> lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral artery, Atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>unknown</b> <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <b>Greene</b>
21. I certify that (I) (this hospital) attended the deceased from <b>4/1-2</b> , 19 <b>66</b> to <b>4/25</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/24</b> 19 <b>66</b> , and that death occurred at <b>10:25</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Weisman</b>		22b. DATE SIGNED <b>4-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Weisman</b>		22d. ADDRESS <b>59 Greene Street Cumberland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. George's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Mt. Savage, Md.</b>
24. FUNERAL DIRECTOR <b>Joseph R. Durst, Sr.,</b>		ADDRESS <b>Frostburg, Md.</b>	
25a. REC'D BY REGISTRAR <b>APR 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04232

STATION OF WORK

04232

APR 23 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Alleghany</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Alleghany</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> 01-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sacred Heart Hospital</u>					d. STREET ADDRESS <u>469 Goethe Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Jesmond Robertson</u>			4. DATE OF DEATH Month Day Year <u>April 24 1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-03</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pa. USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lawson A. Perdew</u>					14. MOTHER'S MAIÖEN NAME <u>Mary Diehl</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Pt. chart</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary heart failure</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>4-24-1966</u> , to <u>4-24-1966</u> , that (I) (we) last saw the deceased alive on <u>4-24-1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>L. Brings</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4-25-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. L. Brings</u>					22d. ADDRESS <u>57 Greene Street</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland Rt3 Maryland</u>		
24. FUNERAL DIRECTOR <u>Ruth E. Silcox</u> <u>Cumberland, Maryland</u>					25a. REC'D BY REGISTRAR <u>APR 27 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

14239

APR 27 1988



8 1 (M)  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04640

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D O A Sacred Heart Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hayes</b> Middle <b>Elwood</b> Last <b>Robinette</b>		4. DATE OF DEATH Month <b>April</b> Day <b>17</b> Year <b>1966</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 7, 1888</b>		9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Flintstone, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Henry Clay Robinette</b>				14. MOTHER'S MAIDEN NAME <b>Minerva Jane O'Neil</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-32-2961</b>		17. INFORMANT <b>Mrs. Mildred Hershberger-Box 233 Cresaptown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO (b) <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 17, 1966</b> EXAMINER'S NAME (Type) <b>Benedict Skitarelic</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John J. Hafer, 230 Baltimore Ave., Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 20 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>							

00000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Allegany

County

City of Baltimore

James M. ...

Age ...

Occupation ...

Married ...

Residence ...

Signature ...

Signature ...



July 17, 1968

County ...

Signature ...

Signature ...

Signature ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04641 CERTIFICATE OF DEATH 04641									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MA W.VA</b> b. COUNTY <b>MINERAL</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>3 DAYS</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>61 CARPENTER AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>XRUMK DOROTHY LORRAINE ROWE</b>		First Middle Last		4. DATE OF DEATH <b>4-29-1966</b>		Month Day Year			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-9-1924</b>		9. AGE (In years last birthday) <b>41</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INSPECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TEXTILES</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
13. FATHER'S NAME <b>CARL SPRIGGS</b>				14. MOTHER'S MAIDEN NAME <b>NETTIE E. SPRIGGS ELBIN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-12-5619</b>		17. INFORMANT <b>HUSBAND HAROLD ROWE</b>		Address <b>Ridgeley, W. Va. 61 CARPENTER AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> 416X DUE TO (b) <b>Chronic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>January</b> , 19 <b>50</b> , to <b>April 24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>April 25</b> , 19 <b>66</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Blaine Schindler</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/29/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Blaine Schindler</b>				22d. ADDRESS <b>43 Greene St. Cumberland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>			
24. FUNERAL DIRECTOR <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

6064

NOV 17 1934

ALLEGANY

61 CARPENTER AVE. RIDGELY, W.V.

3 DAYS

CUMBERLAND

61 CARPENTER AVE.

SACRED HEART HOSPITAL

ROME

DOROTHY

XXXXXX

8-9-1934

WHITE

FEMALE

SPRINGS

SPRINGS

NETTIE E.

CARL SPRINGS

HUSBAND HAROLD ROME

*General Certificate  
of Death*

*at age 44 years*

*11/2/34*

MAY 11 1936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04642

CERTIFICATE OF DEATH

04642

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>23 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>534 GREENE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Herbert</b> Last <b>Sell</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 66</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-13-02</b>		9. AGE (In years last birthday) yrs. <b>63</b>	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Metal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Michael Sell</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET Werner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>PATIENT'S CHART</b>				
MEDICAL CERTIFICATION						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(2) Bronchiogenic CA with generalized</b> DUE TO (b) <b>metastases</b> DUE TO (c) <b>(1) Generalized cachexia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>2 mo</b>
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>N/A</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
						20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (the hospital) attended the deceased from <b>October</b> , 19 <b>65</b> , to <b>4-9</b> , 19 <b>66</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4-9</b> , 19 <b>66</b> , and that death occurred at <b>2:00 PM</b> , from causes and on the date stated above.								
22a. SIGNATURE <b>William Wolverton</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-11-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM WOLVERTON, MD.</b>				22d. ADDRESS <b>108 HARRISON ST., CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumbr. Md.</b>		
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>				ADDRESS <b>Cumbr. Md.</b>		25a. REC'D BY REGISTRAR <b>APR 13 1966</b>		
						25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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FOR STATE  
HEALTH DEPT.

04643  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
04643

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>85-3</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gumbrland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aurora</b>			
c. LENGTH OF STAY IN 1b <b>DOA</b>				d. STREET ADDRESS <b>Box 21</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital--DOA</b>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry W Shahan</b>				4. DATE OF DEATH Month Day Year <b>April 8 19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/6/1912</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>HARRY WILLIAM SHAHAN</b>		14. MOTHER'S MAIDEN NAME <b>CORA DIEHL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W.II 217-10-1997</b>		17. INFORMANT <b>Emelyna Y. Shahan Aurora W.V.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis, Left</b> 4201 DUE TO (b) <b>Coronary Sclerosis, Left</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>April 8, 1966</b> Address (Street, city, town, or county) <b>Gumbrland, Md.</b>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		22. DATE SIGNED					
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					
23b. DATE THEREOF <b>4/11/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>AURORA</b>		23d. LOCATION (City, town or county) (State) <b>AURORA W.V.</b>			
24. FUNERAL DIRECTOR <b>Walter B Burke Rowlesburg W.V.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>APR 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Altoona

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Altoona

Box 21

Altoona, Pa. 15521-0021

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APR 12 1966

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04644

## CERTIFICATE OF DEATH

04644

1. PLACE OF DEATH a. COUNTY <div style="text-align: center;">Allegany</div> <div style="text-align: center;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <div style="text-align: center;">Maryland</div> <div style="text-align: center;">b. COUNTY Allega ny</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center;">Cumberland</div>		c. LENGTH OF STAY IN lb <div style="text-align: center;">1 Day</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center;">Sacred Heart Hospital</div>		d. STREET ADDRESS <div style="text-align: center;">Rt. # 6 Triple Lakes</div>	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">Bertha Marie Shuck</div>		4. DATE OF DEATH Month Day Year <div style="text-align: center;">April 24 19 66</div>	
5. SEX <div style="text-align: center;">Female</div>		6. COLOR OR RACE <div style="text-align: center;">White</div>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <div style="text-align: center;">Sept. 10, 1898</div>	
9. AGE (In years last birthday) <div style="text-align: center;">67 yrs.</div>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center;">Housewife</div>		10b. KIND OF BUSINESS OR INDUSTRY <div style="text-align: center;">Own home</div>	
11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center;">W. Va. Horseshoe</div>		12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">XXXX U S A</div>	
13. FATHER'S NAME <div style="text-align: center;">William D. Lease</div>		14. MOTHER'S MAIDEN NAME <div style="text-align: center;">Anne V. Lark</div>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <div style="text-align: center;">No.</div>		16. SOCIAL SECURITY NO. <div style="text-align: center;">None</div>	
17. INFORMANT <div style="text-align: center;">Mr. Douglas D. Shuck</div>		Address <div style="text-align: center;">Rt. # 3 Rawlings, Md.</div>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="text-align: center;">Acute Cerebral Vascular Accident, presumed</div> DUE TO a hemorrhage (b) <div style="text-align: center;">Hypertensive and Arteriosclerotic Cardiovas-</div> DUE TO cular disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } 4201			INTERVAL BETWEEN ONSET AND DEATH <div style="text-align: center;">10 hours</div> <div style="text-align: center;">years</div>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="text-align: center;">History of old myocardial infarctions and chronic failure.</div>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 1964, to 4-24-1966, that (I) (we) last saw the deceased alive on April 24, 19 66, and that death occurred at 8:50 M, from causes on and on the date stated above.			
22a. SIGNATURE <div style="text-align: center;">Charles R. Doerner, M.D.</div>		22b. DATE SIGNED <div style="text-align: center;">4-25-66</div>	
22c. PHYSICIAN'S NAME (Type) <div style="text-align: center;">Dr. W. Doerner</div>		22d. ADDRESS <div style="text-align: center;">414 N Mechanic Street</div>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center;">Burial</div>		23b. DATE THEREOF <div style="text-align: center;">4/27/66</div>	
23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Biertown Cemetery</div>		23d. LOCATION (City or Town) (County) (State) <div style="text-align: center;">Rawlings, Md.</div>	
24. FUNERAL DIRECTOR <div style="text-align: center;">H. Wayne George</div>		25a. REC'D BY REGISTRAR DATE APR 29 1966	
25b. REGISTRAR'S SIGNATURE <div style="text-align: center;">Charles Judge</div>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

04645

04645

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						e. STREET ADDRESS <b>157 NATIONAL HIGHWAY</b>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOUGLAS SMITH</b>						4. DATE OF DEATH Month Day Year <b>APRIL 25 19 66</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-13-1894</b>		9. AGE (In years last birthday) yrs. <b>72</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mechanical Engineer.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WESTERNPORT, MD.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ROBERT SMITH</b>						14. MOTHER'S MAIDEN NAME <b>ISABELLE BLACK</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>				16. SOCIAL SECURITY NO. <b>274-07-4099</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis with Rt. Hemiplegia</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>33 days</b> <b>8 yrs?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10 am.</b> , 19 <b>66</b> , to <b>25 am.</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>24 am.</b> 19 <b>66</b> and that death occurred at <b>5:20 AM</b> from causes and on the date stated above.											
22a. SIGNATURE <b>W. Alfred Van Ormer</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>25 am. 66</b>			
22c. PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>						22d. ADDRESS <b>122 S. CENTRE ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens LaVale Alleg Maryland</b>				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ADDRESS <b>Ruth E. Silcox Cumberland, Maryland 21502</b>						25a. REC'D BY REGISTRAR DATE <b>APR 29 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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125 NATIONAL ST

MEMORIAL HOSPITAL

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MALE WHITE

WESTPORT, ME.

ROBERT SMITH

ISABELLE ALACK

MEMORIAL HOSPITAL, CUMBERLAND, ME.

21-7-04

122 S. CENTRE ST.

DR. W. A. VAN ORMER



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04646

04646

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Md.</b>	
c. LENGTH OF STAY IN 1b <b>2 days</b>		d. STREET ADDRESS <b>236 Paca St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gideon Boyd Smith</b>		4. DATE OF DEATH Month Day Year <b>April 2 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1872</b>
9. AGE (In years lost birthday) <b>93 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Smith</b>		14. MOTHER'S MAIDEN NAME <b>Betsy Smith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sampson Smith, 236 Paca St., Cumberland, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio-vascular disease</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Hypertrophy of prostate, benign, urinary infection</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10 - 4</b> , 19 <b>65</b> , to <b>4 - 2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive at <b>4 - 2</b> , 19 <b>66</b> , and that death occurred at <b>3p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED <b>4-4-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		22d. ADDRESS <b>62 Greene St. Cumberland, Md. 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glendale Church of Bretheren</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Flintstone, Md.</b>
24. FUNERAL DIRECTOR <b>John F. Hafer</b>		25a. REC'D BY REGISTRAR <b>APR 7 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>230 Baltimore Ave., Cumberland</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

04647

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>1 MONTH</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT SAVAGE</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>BEULAH ARMEDITH THOERIG</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10-12-10</b>		9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CELANESE CORP.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WILLIAM F. THEORIG</b>				14. MOTHER'S MAIDEN NAME <b>HARRIETT A JENKINS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>214-07-2616</b>			16. SOCIAL SECURITY NO. <b>214-07-2616</b>		17. INFORMANT <b>PT'S CHART</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO (b) <b>Hypertensive Heart Disease</b> OUE TO (c) <b>Uremic Poisoning</b>							INTERVAL BETWEEN ONSET AND DEATH <b>30 days</b> <b>15 yrs.</b> <b>30 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cystitis acute, cholelithiasis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			20g. (County)		20h. (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>March 6, 19 66</b> to <b>April 5, 19 66</b> that (I) (we) last saw the deceased alive on <b>April 5, 19 66</b> and that death occurred at <b>9:35 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>James P. Hallinan M.D.</i>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James P. Hallinan M. D.</b> <b>DR. HALLINAN</b>				22d. ADDRESS <b>140 BEDFORD ST. CUMBERLAND, MARYLAND.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APR. 9 '66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. GEORGE EPISCOPAL</b>		23d. LOCATION (City or Town) (County) (State) <b>MT. SAVAGE, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>				25a. REC'D BY REGISTRAR <b>APR 11 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04045

REPORT OF DEATH

04045

1

2

WIND

WIND

WIND

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04648

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04648

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>50 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		01-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>522 LOUISIANA AVE.</b>				d. STREET ADDRESS <b>522 LOUISIANA AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>KARL</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>12</b> Year <b>19 66</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9, 1882</b>		9. AGE (In years last birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINIST</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.M. RAILROAD</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ADOLPH THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>THERESA ?</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>705 10 796 1</b>		17. INFORMANT <b>ELIZABETH LAUER</b> Address <b>CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>974 x</b> IMMEDIATE CAUSE (a) <b>ASPHYXIATION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>STRANGULATION</b> DUE TO (c) <b>(HANGING--SELF INFLICTED)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>MINUTES</b> <b>MINUTES</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22. DATE SIGNED				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>APRIL 12, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>CUMBERLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>BYRON KIGHT</b>				25a. REC'D BY REGISTRAR <b>APR 14 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0400

STATE OF NEW YORK

1911

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IN SENATE

January 11, 1911

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1911



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04649

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04649

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>				c. LENGTH OF STAY IN lb <u>hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hosp.</u>				d. STREET ADDRESS <u>409 Greene St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Howard</u> Last <u>Timbrook</u>				4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1894</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supply Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. &amp; O. Rwy.</u>		11. BIRTHPLACE (State or foreign country) <u>Moorefield, W. Va.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supply Clerk</u>				11. BIRTHPLACE (State or foreign country) <u>Moorefield, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Phillip Timbrook</u>				14. MOTHER'S MAIDEN NAME <u>Anna Sherman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes, W. W. # 1</u>				16. SOCIAL SECURITY NO. <u>212-18-0819</u>		17. INFORMANT <u>Mr. James W. O'Brien</u> Address <u>409 Greene St. Cumb. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>-----</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>Rt. # 9 Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/3/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAY 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04224

MAY 2 1968

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DR. R.J. WILLIAMS

## CERTIFICATE OF DEATH

04650

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 HRS. 45 MIN.</b> <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>109 FEDERAL STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>ELMA</b> Last <b>WARINER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>28</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-4-1907</b>
9. AGE (In years lost birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>01</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CASPER GOETZ</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH KREIGHLEIN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL-CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> 260x DUE TO <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Coronary Artery Disease</b> (b) <b>Coronary Artery Disease</b> (c) <b>Coronary Artery Disease</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>2/2/66</b> , 19 <b>66</b> , to <b>4/28/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>4/25/66</b> , and that death occurred at <b>4:50 AM</b> on <b>4/28/66</b> causes and on the date stated above.			
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>		22b. DATE SIGNED <b>4/28/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 30, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

040250

DR. R. J. WILLIAMS

CERTIFICATE OF DEATH

ALLIANCE

MARYLAND

ALLEGANY

CUMBERLAND

NO. 1. 1. 1. 1.

CUMBERLAND

109 FEDERAL STREET

MEMORIAL HOSPITAL

WASHER

CLINIC

NO. 1. 1. 1. 1.

WHITE

TEMPLE

NO. 1. 1. 1. 1.

HOSPITAL

ELIZABETH WELSH

CASPER DOBIE

MEMORIAL HOSPITAL - CUMBERLAND, MD.

RECEIVED  
MAY 10 1966  
FBI - WASHINGTON  
MAY 10 1966  
FBI - WASHINGTON

DR. R. J. WILLIAMS  
109 S. CENTRE ST., CUMBERLAND, MD.

MAY 3 1966

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

04651

04651

1. PLACE OF DEATH ALLEGANY ALLEGANY CUMBERLAND MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1814 SYLVAN AVE		d. STREET ADDRESS 814 SYLVAN AVE	
3. NAME OF DECEASED (Type or print) First Middle Last LORENZA E. WATKINS		4. DATE OF DEATH Month Day Year APRIL 14 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 2, 1895
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALVAGE TIRE CO		10b. KIND OF BUSINESS OR INDUSTRY KELLY SPRINGFIELD	
11. BIRTHPLACE (State or foreign country) RUCKMAN W, VA.		12. CITIZEN OF WHAT COUNTRY? U SA	
13. FATHER'S NAME EDWARD WATKINS		14. MOTHER'S MAIDEN NAME ELLA DAVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W W I	
17. INFORMANT MADEL STUMP WATKINS		Address 814 SYLVAN AVE. CUMB, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shot Gun Shot Of Abdomen 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted	
20c. TIME OF INJURY Month, Day, Year Hour Min. p.m. 5:00 Apr 14, 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland Alleg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC M.D.		Address (Street, city, town, or county) Cumberland Md.	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF APRIL 16, 1966	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City, town or county) (State) CUMBERLAND, MARYLAND	
24. FUNERAL DIRECTOR Louis Stein Inc.		ADDRESS Cumb. Md.	
25a. RECEIVED BY REGISTRAR APR 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12030

APR 10 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
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M  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04652  
CERTIFICATE OF DEATH  
04652

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>8 HRS.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> d. STREET ADDRESS <b>RT 1 VALLEY RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD LEO WILLIAMS</b>		4. DATE OF DEATH Month Day Year <b>APRIL 19 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-27-1895</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mech. Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN WILLIAMS</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA NEUBAUER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WAR I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO (b) <b>Essential Hypertension</b> DUE TO (c) <b>5 Yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>Michael Glick</b> attended the deceased from <b>Jun 64</b> to <b>19 Apr 1966</b> , that (I) <b>Wm</b> last saw the deceased alive on <b>19 Apr 1966</b> , and that death occurred <b>11 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>L. Michael Glick</b>		22b. DATE SIGNED <b>20 Apr 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. Michael Glick Md.</b>		22d. ADDRESS <b>126 N. Smallwood St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 22, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. READ BY REGISTRAR <b>APR 26 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE	

0103

21

Administrative Information

22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

Page 2 of 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04653 CERTIFICATE OF DEATH 04653									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>8 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> <b>01-1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>					d. STREET ADDRESS <b>712 LINCOLN ST.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>RAY</b> Last <b>WILSON</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 66</b>						
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-20-84</b>		9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Celanese Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Wilson</b>					14. MOTHER'S MAIDEN NAME <b>Jane Robertson</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-05-7205</b>		17. INFORMANT <b>PT'S CHART</b> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senile arteriosclerotic heart</b> <b>260X</b> DUE TO <b>plasma with uricemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>phlebotomy</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>months</b> <b>years</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April 15, 1966</b> , to <b>April 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 16, 1966</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>[Signature]</b>					22b. DATE SIGNED <b>4/27/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>DR. E. SCHINDLER</b>					22d. ADDRESS <b>43 GREENE ST. CUMBERLAND, MARYLAND.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>4/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cumberland Maryland</b>		
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>					25a. REC'D BY REGISTRAR <b>APR 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04654

04654

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>01-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>1501 Holland St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Catherine</u> Last <u>Winebrenner</u>		4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1920</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min. <u>46</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Purchasing Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles H. Winebrenner</u>		14. MOTHER'S MAIDEN NAME <u>Edna H. Feidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>213-18-2633</u>	
17. INFORMANT <u>Mrs. Edna H. Winebrenner</u>		Address <u>1501 Holland St. Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-13</u> , 19 <u>65</u> , to <u>4-8</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>4/18</u> , 19 <u>66</u> , and that death occurred at <u>10:30AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William P. James</u>		DATE SIGNED <u>4/11/66</u>	
PHYSICIAN'S NAME (Type) <u>William P. James</u>		ADDRESS (Street, city or town, state) <u>4111 N. 1st Street, Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter &amp; Paul Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>APR 13 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

1918

<p>1. Name of deceased: <u>John Doe</u></p>	
<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>	
<p>4. Date of death: <u>Jan 15 1918</u></p>	
<p>5. Place of death: <u>Home</u></p>	
<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Signature of physician: <u>Dr. J. H. Smith</u></p>	
<p>8. Signature of registrar: <u>John Doe</u></p>	
<p>9. Signature of informant: <u>John Doe</u></p>	
<p>10. Signature of witness: <u>John Doe</u></p>	
<p>11. Signature of undertaker: <u>John Doe</u></p>	
<p>12. Signature of funeral home: <u>John Doe</u></p>	
<p>13. Signature of cemetery: <u>John Doe</u></p>	
<p>14. Signature of church: <u>John Doe</u></p>	
<p>15. Signature of school: <u>John Doe</u></p>	
<p>16. Signature of other: <u>John Doe</u></p>	

THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04655

CERTIFICATE OF DEATH

04655

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBERG</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>RT. # 2</b>	
3. NAME OF DECEASED (Type or print) First <b>ABRAM</b> Middle <b>WINFIELD</b> Last <b>WINFIELD</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 11, 1884</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <b>ECKHART, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE WINFIELD</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH EVANS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-1447</b>	
17. INFORMANT <b>PATIENT'S E.R. CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of Prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-11</b> , 19 <b>66</b> , to <b>4-11</b> , 19 <b>66</b> that (I) (we) lost saw the deceased alive on <b>4-11</b> 19 <b>66</b> , and that death occurred at <b>2:30 P</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>WOS [Signature]</b>		22b. DATE SIGNED <b>4-13-66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 14, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Eckhart, Md.</b>	
24. FUNERAL DIRECTOR <b>HAFFER FUNERAL HOME, 60 W. MAIN ST.</b>		25a. REC'D BY REGISTRAR <b>APR 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

2020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

04656 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
DR. R.J. WILLIAMS						CERTIFICATE OF DEATH			04656		
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN lb <b>14 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS <b>RT. #3, BEDFORD ROAD</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>MARY (Anna)</b> Middle <b>A.</b> Last <b>WINFIELD</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1966</b>							
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887</b> <b>8-14-1887</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND - Cumberland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN HIMMER</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE KENNIPER</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>260x</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>Plaque Rupture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Atherosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>2/7/66</b> , 19 to <b>4/27/66</b> , 19, that (I) (we) last saw the deceased alive on <b>4/26/66</b> , and that death occurred at <b>4:45 A.M.</b> from causes and on the date stated above.											
22a. SIGNATURE <b>[Signature]</b>				22b. DATE SIGNED <b>4/28/66</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>				22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 29, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

04056

CERTIFICATE OF DEATH

DR. R. J. WILLIAMS

ALLEGANY

MARYLAND

IN DAYS

MEMORIAL HOSPITAL

RT. 11, CEDRON ROAD

MARY

WINEFELD

APRIL 23

FEMALE WHITE

B-14-1903

MARYLAND

BATHING (REINFORCED)

MEMORIAL HOSPITAL - CUMBERLAND, MD.

DR. R. J. WILLIAMS

122 S. CENTRE ST., CUMBERLAND, MD.

MAY 1 1906

*Handwritten signature*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
04657													
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>60 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>York Hotel-202 Baltimore Ave.</u>						d. STREET ADDRESS <u>York Hotel-202 Baltimore Ave.</u>							
3. NAME OF DECEASED (Type or print) <u>George Palmer Wolford</u>			First Middle Last			4. DATE OF DEATH <u>April 24 19 66</u>		Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1905</u>		9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Samuel S. Wolford</u>						14. MOTHER'S MAIDEN NAME <u>Minnie G. Rush</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mr. Glen L. Wolford, Cumberland, Md.</u>		Address <u>Brother</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>												INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema, Cor Pulmonale</u>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u></u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>April 24, 1966</u> 22. DATE SIGNED EXAMINER'S SIGNATURE <u>Benedict Skitarellic</u> M.D. EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Apr. 27, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>					
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

0455

NEEDLE EXAMINER'S CERTIFICATE OF STATE

CORONARY OCCLUSION

CORONARY SCLEROSIS

Infarcted Myocardium, Cor Pulmonale

X

X

X

X

X April 24, 1906  
Dunbar, N.Y.

Robert S. Kline, M.D.

May 1 1906



04658

CERTIFICATE OF DEATH

04658

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>8 DAYS</b>	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		d. STREET ADDRESS <b>37 BROWNING ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>GRACE A. WOLFORD</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>19 66</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 8, 1898</b>		9. AGE (In years last birthday) <b>68</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-Cumberland</b>		12. CITIZEN OF WHAT <b>U.S.A.</b>		13. FATHER'S NAME <b>DENTON BUCY</b>		14. MOTHER'S MAIDEN NAME <b>MARY HUFF</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> (c) <b>Congestive Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 18, 1966</b> to <b>April 26, 1966</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1966</b> and that death occurred at <b>8:45 P.M. April 26, 1966</b> , from causes and on the date stated above.													
22a. SIGNATURE <b>G. Overton Himmelwright</b>		22b. DATE SIGNED <b>4/26/66</b>		22c. PHYSICIAN'S NAME (Type or print) <b>DR. G. OVERTON HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE. CENTRE ST. CUMB. MD.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 29, 1966</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Lybarger Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Madley, Penna.</b>		24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>MAY 3 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

05658

CERTIFICATE OF DEATH

01857

ALLIANCE

MARTIN

ALLIANCE

CHURCH AND

8 DAYS

CUMBERLAND

57 BROWN ST.

MEMORIAL HOSPITAL

HOLFORD

GRACE

MARCH 8, 1938

FEMALE WHITE

MARYLAND

MARY HILL

GENON BUCK

MEMORIAL HOSPITAL

DR. W. H. HARRIS, JUN. NO.

DR. W. H. HARRIS, JUN. NO.

MAY 1938

MAY 1938

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS AND THE PHYSICIAN IN CHARGE OF THE HOSPITAL OR CLINIC IN WHICH THE DECEASED WAS RECEIVED. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

14/ FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any other is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/63

Item 18-11m G376 57- MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 04659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04659											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG,						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG,					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 155 GREEN STREET						d. STREET ADDRESS 155 GREEN STREET					
3. NAME OF DECEASED (Type or print) MARGARET C. WOODS						4. DATE OF DEATH APRIL 22nd, 1966					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 23rd, 1914		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR PAJAMA FACTORY						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME RUSSELL FORSYTHE						14. MOTHER'S MAIDEN NAME IDELLA WRIGHT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO. 213-22-3938		17. INFORMANT MRS. IDELLA W. STEVENS, FROSTBURG, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Fatty Liver 880.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ethanol Poisoning DUE TO (c) Acute alcoholism INTERVAL BETWEEN ONSET AND DEATH Days ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Frostburg		(County) Alleg.		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> APRIL 25, 1966 DATE Address (Street, city, town, or county) RD 2, CUMBERLAND, MD.											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-25-66		22c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		22d. LOCATION (City, town, or county) FROSTBURG,		(State) Md.		24b. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR JOSEPH R. DURST, SR.,						ADDRESS FROSTBURG, MD.		24a. REC'D BY REGISTRAR APR 28 1966			

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